Cooperative Agreement No. AID-486-A-11-00011

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THE SCIENCE OF IMPROVING LIVES

Smart TA

Sustainable management of the HIV/AIDS response and transition to TA project

FY14/COP13 Semi-Annual Report (October 2013 - March 2014)

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Executive summary

The USAID *Sustainable Management of the HIV/AIDS Response and Transition to Technical Assistance Project* – or "SMART TA" – is a five-year, $45 million initiative managed by FHI 360 that strives to ensure the provision of quality, comprehensive and sustainable HIV services through a strengthened national response. It is designed to contribute directly to the targets identified in the *National Strategy on HIV/AIDS Prevention and Control in Vietnam* and the *Partnership Framework between the Government of the United States of America and the Government of the Socialist Republic of Vietnam for HIV/AIDS Prevention and Control.*

This document constitutes SMART TA's FY14/COP13 semi-annual report for the period 01 October 2013 to 31 March 2014. The following sections outline:

- Trends and paradigms
- Success vision
- Progress towards Year 3 strategic objectives and program indicators
- Project management and personnel
- FY14/COP13 work plan deliverables (Annex 1)
- Results against targets (Annex 2)
- MMT scale up progress table (Annex 3)
- Gender analysis for SMART TA (Annex 4)
- SMART TA stories (Appendix 5)

Important trends, changing paradigms

Every drop we lose is a lost resource, effort, opportunity . . . life
SMART TA cascade video

We are at a tipping point in the fight against HIV. We have the tools that can help us look at the epidemic with a new lens. Our comprehensive approach can support enhanced coordination across implementing partners and donor agencies. Our strategies can increase program and cost efficiencies, and align funder and Government (GVN) priorities for impactful interventions at the district, provincial and central levels. We have a plan that expands in-country capacity for a sustainable response.

Important trends, however, stand in the way of a Vietnam AIDS-free generation:

1. Substantial, local HIV epidemics are occurring in poorly or underserved areas across the country.
2. PLHIV are often not seeking testing and, after testing positive, may not be linked into continuous care until they are ill.
3. The rate and number of individuals newly initiating ART is not growing or declining in most service sites, and a significant proportion of clients are dying, dropping out of treatment or being lost to follow up.
4. Coordination across provincial service systems remains fragmented and focused on "project-based" interventions.

5. In country TA and capacity building strategies lack strategic focus, effort and coordination.
6. Donor resources are declining and service system costs require continual monitoring and refinement to ensure that available resources are used most effectively and lead to sustainability.

USAID/SMART TA believes that these challenges are surmountable, if we work together in strategic ways. Three components make up our operating framework.

CoPC cascade model

USAID/SMART TA uses the cascade conceptual framework (Figure 1) to illustrate how individuals move – or don't move – through a health service continuum of care. By identifying, monitoring and reducing the "leaks", we can support GVN health service systems to be better performing, more efficient and, ultimately, more impactful.

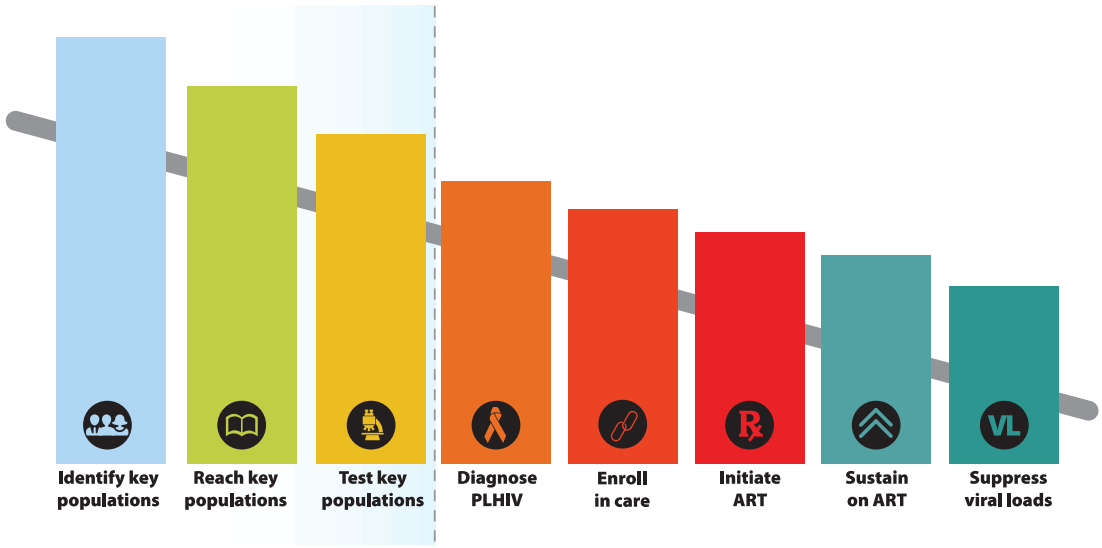

Figure 1|Continuum of HIV prevention and care (CoPC) cascade

The cascade model underlies all three SMART TA strategic objectives[1]:

1 Deliver quality HIV services within the CoPC. SMART TA supports cascade service approaches that (a) prioritize highest risk individuals and their partners in primary prevention efforts; (b) test and identify HIV positive individuals; (c) immediately link and retain PLHIV in HIV care and treatment services; (d) initiate timely ART; (e) sustain individuals on ART and (f) suppress viral loads to extend life and reduce HIV transmission risks.

2 Strengthen GVN and SO technical capacity. SMART TA assists national, provincial, district GVN and civil society organizations (CSOs) to understand and more effectively program their HIV response (and other health services) across the cascade. SMART TA technical assistance ensures that strategies are evidence-based, of good quality and locally feasible and sustainable.

3 Transition financial, administrative and technical ownership of CoPC services. As implementers view the HIV response through the lens of the cascade, they can refocus resources (whether they be financial, human and technical) in more strategic and cost efficient ways, working towards the SMART TA goal of "transitioning a minimum of 40% of USAID-supported CoPC interventions, partners and sites to GVN and local partners."

"Push" and "pull" TA systems

We define technical assistance as "a dynamic, capacity-building process for designing or improving the quality, effectiveness and efficiency of specific programs, research, services, products or systems" (West et al 2012)[2]. Utilizing a combination of *"push"* (promoting new knowledge, findings and best practices) and *"pull"* (facilitating access to technical information and skills) TA methods, USAID/SMART TA strives to increase the capacity of GVN

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[1] Strategic objective wording has been slightly revised to reflect the nature of this iterative program

[2] West, G., Clapp, S.P., Davidson Averill, M.E., & Cates Jr., C. (2012). Defining and assessing evidence for the effectiveness of technical assistance in furthering global health. *Global Public Health: An International Journal for Research, Policy and Practice*. DOI: 10.1080/17441692.2012.682075

and CSOs to manage, coordinate, deliver and monitor the HIV response. Our approach can be broadly conceptualized as follows:

Figure 2|Push and pull TA systems

In Year 3, USAID/SMART TA introduces, strengthens, tracks and monitors coordinated push and pull TA efforts across provinces and projects. Particular attention is placed on supporting sustainable TA networks at the provincial and central levels; assisting partners to introduce blended learning capacity building measures; and trialing innovative service models.

Joint provincial planning and implementation

Progress towards full country ownership has been slow because: (a) current service models are too expensive to sustain; (b) critical questions such as how to finance a sustainable supply of antiretroviral drugs and methadone have not yet been fully answered; (c) service systems in most provinces are still heavily dependent on donor funding and fragmented across projects; (d) provinces lack important technical capacities for sustainability; and (e) political commitment at different levels of government is low.

USAID/SMART TA is placing its primary focus at provincial and district levels in Year 3. We support provinces to collaboratively plan and act (see Figure 3) for greater impact and cost effectiveness. Increased support for joint provincial planning will help Provincial AIDS Committees (PACs) and Provincial Health Services (PHS) gain the capability to use the cascade framework and other tools to review service system performance, develop provincial priorities, increase efficiencies, and link and coordinate services and interventions.

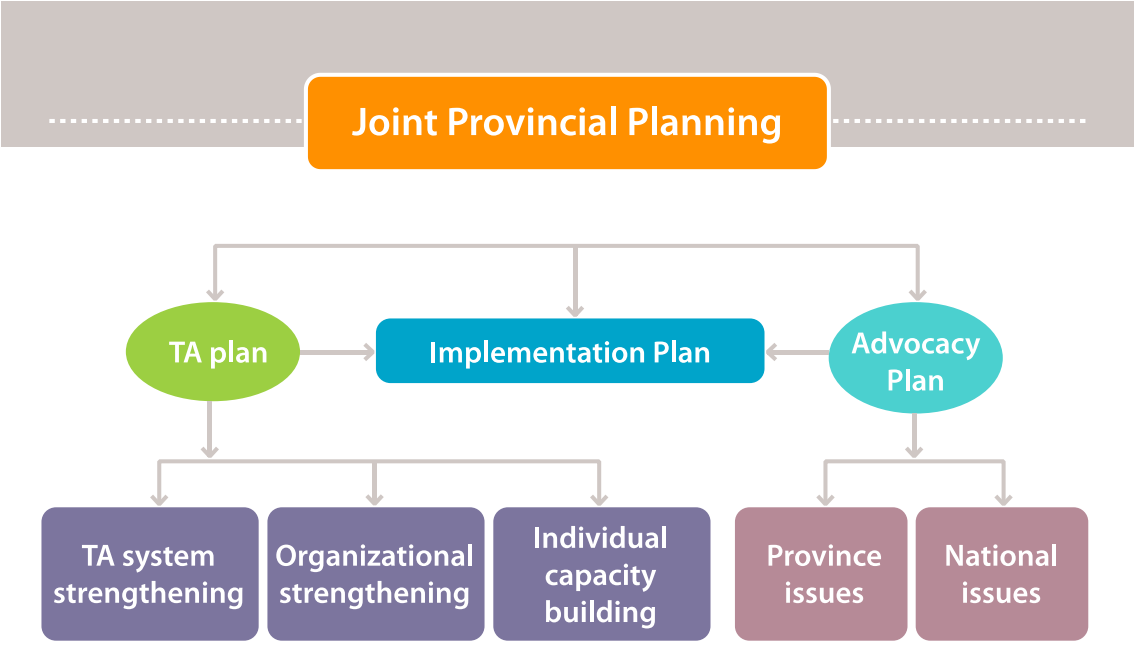

Figure 3|Joint provincial planning focus

Responsive technical and financial assistance (based on assessment of real situations) will assist provinces and districts in placing greater priority for extending services to underserved or poorly served areas. Time-limited financial support, coupled with a systems strengthening focus, will promote local ownership and increase sustainability. Technical support will help ensure HIV programs and services are evidence-based. And use of the cascade framework in implementation will help provincial authorities to strategically refocus CoPC programming that generates better results more cost effectively and efficiently.

Visioning success

USAID/SMART TA's paradigm for action is designed to support GVN to:

1. Reach the 3 zeros and the specific goals identified in the *National Strategy on HIV/AIDS Prevention and Control in Vietnam* by improving CoPC cascade performance and focusing on results;
2. Increase the capacity of GVN and CSOs to develop, implement, manage and monitor HIV programming, irrespective of funding source.
3. Decrease GVN dependency on external funder support to deliver and sustain the HIV response.

We believe success requires open collaboration across partners; application of current science and global best practice; promotion of sustainability in system design and implementation; responsiveness and commitment of well-trained staff; and flexibility to react to changing program realities, issues and challenges.

USAID/SMART TA is only one player in a comprehensive, joint effort. To illustrate what success looks like and our relative contributions, we have prepared the following conceptual framework that outlines our work in Year 3:

FY14/COP13
SAR achievements

OBJECTIVE I | Deliver quality services within the CoPC

USAID/SMART TA works with GVN, PEPFAR, CSOs and other key stakeholders to operationalize sustainable, efficient and evidence-based CoPC models and improve HIV service system performance in medium and low resourced provinces across the country. Two priority areas underpin Objective I:

1. Improve cascade performance
2. Pay for results

Improve cascade performance

USAID/SMART TA recognizes that "we do not want to transition a broken system." In Year 2, we introduced the cascade model to central, provincial and local GVN and CSO representatives. We supported provinces to prepare provincial cascades that identified leaks in their service systems. We developed the beginnings of a SMART technical monitoring approach (using key cascade metrics) to distinguish the kind and intensity of support implementers/sites require. We expanded methadone maintenance treatment, mobile HTC, and "3 in 1" facilities. We provided technical assistance to improve TB/HIV linkages; to introduce community-based FSW harm reduction; and to begin HIV service provision in prisons. We initiated research to understand how clients move through HIV care and treatment

services; to highlight differences in clinic staff efficiency as per the number of patients; and to ascertain the degree of viral load among pre-ART clients.

Year 3 is a period of expansion, standardization, enhancement, and innovation, when we work to respond to the barriers that stand in the way of Vietnam's national success[3].

1. Local HIV epidemics are occurring in 'underserved' areas.

(a) *Expand MMT, "3 in 1", satellite and mobile services in highest priority districts.*

Lead units: MMT, HIV Care & Treatment, and Technical Assistance Coordination and Health Systems Strengthening (TACHSS)
Results:

FY14/COP13 Target	SAR Achievement
8 new MMT clinics	• 3 sites will open May 2014 • 9 sites undergoing renovation and equipment installation
12 new MMT satellite services	8 dispensing sites in Dien Bien and Hai Phong awaiting local government budgetary approval
Up to 5 new 3-in-1 services	5 3-in-1 service sites in implementation or final preparation
4,580 (Total number of people who inject drugs on medicine-assisted therapy – DSD target)	5,295 total clients at 20 MMT facilities (4,806 clients – 4647 males + 159 females – have been on treatment more than 3 months)

Completed Ongoing

As of March 2014, 5,295 patients were enrolled in **MMT** at 20 USAID/SMART TA-supported clinics across nine provinces. Approximately 4,806 clients – 4647 men and 159 women – had availed treatment services for more than three months. Over the reporting period, the number of MMT patients increased by 553 patients or 11.6%. USAID/SMART TA now supports 33% of the total patients in Vietnam's MMT national program.

[3] Annex 1 includes a listing of all expected FY14/COP13 deliverables; while Annex 2 highlights achievements against numerical targets

During this phase of MMT scale up, USAID/SMART TA's support focuses on the provision of TA and minimal set up costs for poor, high-priority districts. Local government is expected to cover the infrastructure and assume operational costs for new MMT clinics and/or satellite services in their province/districts.

Our TA protocol for new clinic or satellite site establishment consists of the following four steps:

1. Support needs assessment and provincial planning processes.
2. Provide TA on clinic floor plan design and follow-up on facility renovation, equipment procurement and installation.
3. Facilitate staff capacity building, including one week accreditation training and one week practicum training.
4. Comprehensively support clinics during the first 3 months of the MMT Induction phase.

Over the reporting period, three MMT sites (Thot Not in Can Tho; Thai Binh in HCMC; and Vinh Niem in Le Chan-Hai Phong) have completed the preparation process and will open to the public in May 2014. Nine additional sites are currently undergoing facility renovation and equipment installation, while eight dispensing sites in Dien Bien and Hai Phong are waiting for local government budgetary approval before initiating treatment services. Annex 3 outlines our progress towards MMT service scale up in greater detail.

We continue to advocate for the integration of **3-in-1 services** in all targeted provinces as a critical strategy for streamlining service costs, improving efficiencies, and better supporting client needs. In the first six months of FY14/COP13, we finalized MMT-ART-HTC standard operating procedures and expanded/strengthened 3-in-1 services in Thot Not (Can Tho), Thu Duc (HCMC), Que Phong and Que Chau (Nghe An) and Tua Chua (Dien Bien). In Thu Duc, 78 patients – or 25% of the total MMT patient load – receive both MMT and ART services. All staff in 3-in-1 facilities supported by USAID/SMART TA have been trained in the provision of MMT and ART and doctors provide both methadone and ARV prescriptions. Functional rooms and patient flow have been re-arranged based on master integration plans.

In Tho Not, Can Tho, existing HIV care and treatment staff were trained on MMT provision in 2013. Methadone services will be initiated in May 2014.

USAID/SMART TA currently supports 23 **mobile HIV testing and counseling (HTC) services,** with two new mobile HTC services initiated over the semi-annual period. Between October 2013 and March 2014, 5191 individuals were tested for HIV. The HIV positivity rate for those testing averaged 2.97%.

(b) *Introduce 'reach, test, treat and retain' mountainous model.*

Lead units: All technical units and TACHSS
Results: 'Reach, test, treat and retain' strategy developed, implemented and monitored in selected provinces

Completed Ongoing

USAID/SMART TA continues to work with USAID, PEPFAR and VAAC to develop and introduce a "reach, test, treat and retain" initiative in mountainous areas, utilizing refined testing protocols, emphasizing immediate treatment for HIV positive individuals, and mobilizing a community-based GVN workforce. In Nghe An and Lao Cai provinces, USAID/SMART TA supported expansion of 3-in-1 services in Van Ban and Bat Xat districts (Lao Cai province) and Que Phong and Quy Chau (Nghe An Province). More than 1000 individuals in Nghe An have since utilized mobile HIV testing services and 151 PLHIV (74 newly initiating) are receiving care and treatment services.

USAID/SMART TA developed the "Toi Muon" model that mobilizes hamlet health workers to reach-test-retain vulnerable members of their remote communities. Hamlet health workers (HHW) are provided with performance-based incentives when they (a) conduct a simple risk screening of community members to identify low and high needs individuals; (b) identify a newly HIV positive person (as per testing outcomes); and (c) find and (re)-engage a PLHIV in care. Over the course of the reporting period, we developed paper-based HHW job aides (paper-based), the PBI scheme and the Toi Muon training package. Four one-day trainings were conducted for 72 hamlet health workers in Nghe An and 58 HHWs in Lao Cai. To ensure that the performance-based incentive strategy can be

tracked and easily managed at both the district and provincial levels, USAID/SMART TA has developed mCare – a case management application that utilizes mobile technologies. The full mCare system will be rolled out in May 2014 and may be used as a key tracking tool to reach-test-retain clients across the HIV cascade.

2. PLHIV are not seeking testing, and after testing positive, may not be linked into continuous care until they are ill.

In Year 3 of the program, USAID/SMART TA supports initiatives that substantially increase the number/proportion of clients newly testing positive and immediately entering care and treatment services. Key initiatives over the semi-annual reporting period include:

(a) *Explore gender and LGBT service access issues.*

Lead units: Prevention/Senior Management
Results: Gender/LGBT assessment with priority actions

Completed Ongoing

USAID/SMART TA retained two gender specialists from FHI 360 headquarters to conduct a gender analysis of the SMART TA initiative. The analysis sought to (i) identify ways in which the unequal roles and opportunities of women, men and sexual minorities affect HIV-related health outcomes within the SMART TA context; (ii) assess the degree to which USAID/SMART TA is working to reduce gender inequality in order to improve health outcomes (using USAID's five gender analysis domains); and (iii) identify opportunities for SMART TA to contribute to gender equality while it strives to achieve positive health outcomes.

Interviews were conducted with all SMART TA technical teams and with staff at seven implementation sites in October 2013. The assessment culminated with nine concrete actions for gender integration that will take place over the next 3-12 months. They include:

- Ensuring that, at a minimum, all SMART TA technical staff enroll and take USAID's short e-learning course on Gender 101: Gender Equality at USAID
- Advocating for gender issues, gender sensitivity and gender awareness training to be included in national HIV services training curricula at the pre-service and in-service levels and for continuing medical education
- Incorporating gender integration capacity building into USAID/SMART TA's TA network training package
- Ensure gender disaggregation of data in reporting and presentations

We are in the process of developing our gender action plan that actualizes many of these recommendations over the next SAR period. The full gender report is included in Annex 4.

(b) *Understand reasons for late entry to HTC and HIV care & treatment.*

Lead units: Care and Treatment, Strategic Information (SI)
Results: Completed assessment(s), dissemination and use of findings

Completed Ongoing

Early ART is associated with lower morbidity, increased survival and reduced likelihood of HIV transmission. Currently, however, only 40% of women and 36% of men diagnosed with HIV are engaged in care and meet the ART eligibility criteria of ≤350 cells/mm.

USAID/SMART TA completed a survey at three HIV outpatient clinics during the semi-annual period. Almost 200 (n=196) clients participated, including 39% females and 61% males. Approximately 33% reported previous or current injection drug use.

Clients tended to enroll in care anywhere from 30-90 days or more than 180 days, following the first HIV positive test. Feeling healthy was cited as a key reason for delayed enrollment, while fear of stigma and work/school conflicts also contributed to delays.

To respond to these barriers, we rolled out "I Want" or "Toi Muon" – a communications strategy that aims to reduce barriers that stand in the way of positive behaviors and ultimately works to improve cascade performance. Tools developed under this banner include (a) HTC counselor flipchart; (b) two videos and two client cards for HIV positive or HIV negative diagnosis. Messaging here stresses partner testing and immediate treatment for HIV positive clients and 6-month testing and risk reduction behaviors for HIV negative clients; (c) HIV testing promotion cards targeting MSM and FSWs; (d) the enhanced outreach promotional package; and (e) the care and treatment flipchart for outpatient staff. All materials are currently being field tested in SMART TA-supported sites or interventions.

Stigma and discrimination reduction also is a critical strategy to ensure greater service accessibility and uptake. In addition to the enhanced outreach and community supporter initiative (that offers support for uptake), we are updating a service provider stigma reduction training package, which will be delivered over the following semi-annual reporting period.

(c) *Introduce, strengthen and/or expand service models to increase HTC uptake and C&T enrollment.*

Lead units: Prevention, SC, TACHSS
Results: 60% KPs screened as "high risk"; up to 40% increase in proportion of KPs and partners testing for HIV; at least 50% of newly diagnosed PLHIV are first time testers; at least 70% newly diagnosed PLHIV are enrolled in care and treatment within 1 month of diagnosis; demand creation SC package; community supporter roles/responsibilities, job aides, SOPs

FY14/COP13 Target	SAR Achievement
45,100 key population individuals reached with individual and/or small group level preventive interventions	21,302 (11,465 males and 9,837 females)
Enhanced outreach strategy and service package	Developed and in field testing (9 provinces)
Innovations introduced, tested and scaled up	4 innovations developed, in field testing and/or in scale up

Completed Ongoing

USAID/SMART TA's HIV prevention approach strives to develop and/or enhance community-based programming that "reaches, tests, [treats] and retains" key populations in measurable and, ultimately, sustainable ways.

USAID/SMART TA has developed an **enhanced outreach technical assistance package,** or menu of resources, that constitute our *core* provincial support. This package of technical assistance is being offered to all SMART TA-supported provinces and districts, and extended to other donor-funded initiatives, as per district or provincial requests.

The package of TA resources includes tools and mechanisms that enhance efforts to reduce key population risks and exposure. The resource package also introduces resources that help PACs, district authorities, and CSOs to implement more cost-efficient programming that demonstrates contributions to cascade outcomes. The package encompasses the following:

- *Paper-based job aides* that help the existing prevention workforce to (a) distinguish individuals from outreach contacts; (b) segment key populations based on behavioral risks; (c) systematically assess risks and provide customized support; (d) expand coverage to intimate partners; and (e) systematize the promotion of service referrals[4] and document service uptake. Job aides also assist managers to aggregate data provided by the prevention workforce and to track individual performance-based incentives.

- *Paper-based referral slips and system* that allows PACs, district authorities or CSOs to (a) track the effectiveness of outreach (e.g. reach leading to service uptake); (b) improve data quality; (c) document contributions to cascade outcomes; and (d) track performance-based outreach incentives, across seed, "first-line" and "second-line" implementers.

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[4] The enhanced outreach job aides respond directly to the reporting requirements of the new MER indicators.

- *Performance-based incentive (PBI) package(s)* that move away from monthly stipend payments and towards a system that pays for contributions to specific cascade outcomes.

- *Peer-driven intervention (PDI) approach* that allows PACs, district authorities or CSOs to immediately deploy PDI – informed by respondent-driven sampling methodologies – to expand intervention coverage.

- *Performance metrics for enhanced outreach* that forms the basis for making performance-based incentive payments to the prevention workforce. Key cascade metrics here focus on (a) clients newly testing for HIV in the past 6 months (or 2X/year testing); (b) new HIV cases identified; (c) HIV cases newly registered in care; and (d) LTFU individuals re-engaged in care.

- *TA training strategy/package* that builds and draws upon PAC and VAAC human resources as training partners, as part of USAID/SMART TA's TA network building strategy

Over the semi-annual period, we conducted (a) an enhanced outreach orientation consultation for key PAC and CSO representatives across 9 provinces; (b) two training of trainers (ToT) for 40-45 provincial master trainers; and supported (c) provincial capacity building sessions for community-based supporters, health personnel, and management in areas such as HCMC, An Giang, and Hai Phong. Intensive monitoring will take place in the first three months of adoption to ensure that (a) provinces, districts and/or CSOs are using tools and resources correctly; (b) we have gathered feedback on further customization and/or modification of resources or approaches that may be needed: and (c) we collect key data that informs our QI efforts.

Like the enhanced outreach technical assistance package, USAID/SMART TA has developed (and will continue to add to) a **"menu" of innovations** that provinces, districts and CSOs can pull from. These innovations currently include:

- *The Hamlet Health Worker model.* This model mobilizes hamlet health workers to reach-test-retain vulnerable

members of their remote communities. Resources include HHW job aides (paper-based), PBI scheme, training package and ongoing mentoring support. It is currently being tested in Nghe An and Lao Cai provinces.

- *mCare system.* Client tracking and performance management information system that tracks performance-based incentives to HHWs and other community-based workers who identify new HIV cases, support PLHIV to newly register in care, and re-engage LTFU individuals in treatment. TA tools and support include (a) installation (and customization) of the mCare system; (b) training package (for HHWs, facility-based staff and PACs); and (c) ongoing ICT technical assistance to provinces and districts. mCare is (or will be) piloted in Nghe An, Lao Cai, Dien Bien and possibly other mountainous model provinces.

- *Fansipan model and/or ICT system.* Fansipan uses gamification and mobile technologies to (a) increase coverage of HIV prevention interventions through a gamified, PDI approach; (b) track uptake of HIV testing and enrollment/reengagement in care; and (c) improve data quality and generate "real-time" data. The Fansipan model is being adapted for use with different key populations (e.g. FSWs and MSM) and customized to track PBIs. Because the enhanced outreach tools have been developed for use with both paper-based and mobile formats, the Fansipan ICT system can easily be used to augment or transition existing paper-based approaches and dramatically cut down on staff workload and reporting duties. Like mCare, the TA package includes (a) installation (and customization) of the Fansipan model and/or system; (b) training package; and (c) ongoing ICT technical assistance to provinces, districts or CSOs. Fansipan is now in the process of scale up across 7-9 provinces.

- *TestHCMC.* This approach utilizes social and multi-media approaches to (a) expand coverage of MSM programming and access hard-to-reach sub-populations, e.g. young MSM; (b) mobilize networks of MSM to test for HIV (and track uptake); (c) link MSM to HIV testing and care/treatment service networks; (d) utilize social media analytics and other real-time data (e.g. from Fansipan ICT system) to monitor and modify

program implementation. It is currently under development – in collaboration with the HCMC PAC and APCOM – and will be introduced over the next semi-annual period.

In some cases, the implementation of items on USAID/SMART TA's innovation "menu" will be subject to more detailed evaluation and comparison studies. Like enhanced outreach interventions, our prevention technical team (assisted by SI and other programmatic units) will provide intensive monitoring over the first 3-6 months of adoption.

(d) *Support CoPC service provision in closed settings.*

Lead units: Care and Treatment, TACHSS (HTC)
Results: Closed settings strategic framework and TA plan; prisoners tested for HIV and ART-eligible PLHIV receive anti-retroviral therapy in targeted closed settings

Completed Ongoing

As the Ministry of Public Security (MoPS) preferred TA partner, USAID/SMART TA will play a strategic TA role in supporting CoPC service provision in closed settings. In the first half of FY14/COP13, we conducted site assessments in five prisons located in Quang Ninh, Ha Nam, Hau Giang, Ninh Thuan and Bac Giang. Together with MoPS and VAAC, we developed the technical model for providing HIV testing and care and treatment services in prisons, and finalized the SoPs. Three new sub-agreements and two amendments were developed and approved over the reporting period. We also have finalized the training materials and carried out training with key service provider personnel. Both HIV testing and care and treatment services will commence in June 2014.

(e) *Conduct advocacy and TA measures that have a major health impact.*

Lead units: SC, Prevention, MMT Program
Results: MMT campaign and feedback; FSW community-based harm reduction model strategy and roll out plan serving up to 1000 women

Completed Ongoing

USAID/SMART TA conducted a two-month multi-media campaign to inform the general public and GVN decision makers about the need for MMT scale up. Key messages of "Get Out and Go On" focused on the health, safety and development benefits associated with MMT scale up for individuals, families and Vietnamese society. Over the course the campaign, 22 print articles, 24 online articles and 32 media broadcasts were produced; TV spots were shown 4 times per day for 10 days; 3396 likes were obtained on the dedicated Facebook page; and almost 500 people signed a MMT scale up petition. A survey of 734 visitors to the "Get Out and Go On" photo exhibition illustrated favorable attitudes towards methadone, with respondents agreeing that methadone brings hope to drug-addicted individuals and their families (see Figure 4).

Figure 4|MMT campaign responses

The campaign culminated with the "Solutions to Expand and Sustain the MMT Program" workshop on January 6, 2014. "We have to restructure the budget [for MMT]," explained Professor Chung A, member of the Advisory Board to the Government Office of the National Committee for Drug, Prostitution and HIV/AIDS Prevention and Control. "Vietnam has been too accustomed to international donors. Now we know how beneficial MMT is, and thus we need a specific budget for it."

The campaign provided the platform for Deputy Prime Minister Nguyen Xuan Phuc to publicly request the Ministry of Health to be more proactive in MMT scale up. Following the workshop, 41 provinces have made requests to open 161 new MMT clinics and/or satellite services (105 clinics in 2014; 48 clinics in 2015; and 8 clinics in 2016-2020).

In the evolving model of shared costs, all MMT services will be supported and sustained from provincial resources, with donors supporting only TA and methadone at least until the country's manufacturing production is operating at the needed capacity. A subsequent Ministry of Health meeting, held on January 21, 2014, identified key actions needed for MMT scale up. Highlights of decisions made and actions planned include:

- *Medication Procurement:* Accelerate procurement of methadone medication to meet increasing demand, preferably locally manufactured.
- *Satellite Clinic Guidelines:* Accelerate the process to approve guidelines for MMT satellite clinics to extend capacity of hub clinics.
- *Mentor Training:* Endorsement by the MoH of the list of new local mentors/trainers to support the capacity building/training needed for scale up.
- *Requests to Donors:* Request donors to support for additional new MMT clinics.

3. The number of individuals newly initiating ART is not growing and a significant proportion of clients are dying, dropping out of treatment or are lost to follow up.

Experts and implementers recognize that the suppression of viral loads is the single most important goal of HIV service delivery systems. By reducing viral loads to undetectable levels, programs can extend lives, reduce opportunistic infections and limit risk of HIV transmission to others. For these benefits to apply, however, we must support key populations to test regularly, detect HIV infection early (before the immune system is severely damaged), and initiate ART upon eligibility. PLHIV must also stay in care and adhere to ART. Finally, we must develop and implement a low cost methodology to monitor the extent to which viral loads are being suppressed among those sustained on ART.

In the first half of FY14/COP13, 23,581 persons tested for HIV and 16,983 PLHIV are receiving ART. USAID/SMART TA is supporting the implementation of PMTCT+ in Nghe An and Lao Cai, and is currently preparing two sites for integrated TB/HIV service provision. Other key activities are detailed below.

FY14/COP13 Target	SAR Achievement
60,450 individuals who received HIV Testing and Counselling (HTC) services for HIV and received their test results	23,581
21,110 HIV positive adults and children receiving a minimum of one clinical service at facility	19,688
2500 adults and children with advanced HIV infection that are newly enrolled on ART	1334

(a) *Systematize community-based supporter systems across all USAID-supported provinces.*

Lead units: Prevention, SC, Care and Treatment (CHBC)
Results: Phased community supporter systems strengthening strategy for 12 provinces; up to 40% increase in proportion of KPs and partners testing for HIV; at least 50% of newly diagnosed PLHIV are first time testers; at least 70% newly diagnosed PLHIV are enrolled in care and treatment within 1 month of diagnosis; 80% of PLHIV are retained in care (do not miss appointments); CD4 levels upon HIV initiation increase by agreed % in targeted sites

Completed Ongoing

USAID/SMART TA's enhanced outreach approach extends the SoW of the traditional prevention workforce (e.g. peer educators, outreach workers). Individuals implementing the enhanced outreach approach now become community-based supporters (CBS) tasked with reaching key populations and supporting these persons to test for HIV and to enroll and be retained in HIV care and treatment services, if they are HIV positive. Preliminary feedback on this change has been extremely positive. "I think this approach is fairer," says Mr. Dinh, a CBS in Hai Phong. "It will promote efficiency because, we do more, we get more." Ky Ky, another CBS adds that, "As I am registered to be a CBS, I accept this challenge and want to prove my expertise with [KP] networks and help them."

We also have revised CHBC programming to prioritize high needs clients – including newly diagnosed PLHIV, those who have missed appointments, and PLHIV newly initiating ART. CHBC supporters will ensure that PLHIV are retained in care and are not lost to follow up. Over the first semi-annual reporting period, all tools were finalized and implementers trained in An Giang, HCMC and Hanoi. The following reporting period will assess the impacts of these new approaches – particularly in HCMC and Hanoi where targeted CHBC interventions have been combined with a PBI scheme to reward implementers who achieve cascade results. The next reporting period will also be an opportunity for USAID/SMART TA to further develop its CBS+ strategy that will link all community-based programming across a coordinated approach.

(b) *Enhance pre-ART, early warning and loss to follow up (LTFU) responses.*

Lead units: Care & treatment
Results: Pre-ART service package and approach; early warning system operationalized as part of SMART monitoring approach; LTFU interventions review and strategy

Completed Ongoing

During the past six months, USAID/SMART TA has developed an excel-based early warning tool to identify and predict LTFU risks for pre-ART and ART clients. This tool is now in the process of being validated, and will be in use over the next semi-annual period. Early warning indicators have also been incorporated into the outpatient clinic e-logbook, which automates reporting to ensure better patient monitoring and support. The e-logbook will be piloted in targeted outpatient clinics in June 2014.

USAID/SMART TA has further finalized a combined retention strategy and SoP to decrease loss to follow up. We are implementing a LTFU study, including a mortality analysis, to distinguish deceased clients from those who are LTFU. We believe this information, together with targeted tools, will help provinces retain PLHIV in care and treatment services, whether they are pre-ART or are receiving ART.

(c) *Field test referral system models.*

Lead units: SC (ICT), SI, Care and Treatment
Results: Operationalized referral systems in targeted provinces

Completed Ongoing

Effective referral systems in Vietnam continue to be hampered by (i) project-based referral networks; (ii) vertical health systems; (iii) cumbersome processes that tag individuals as high-risk, may not promote confidentiality and potentially increase risks for stigma and discrimination; and (iv) difficulty verifying successful referral uptake. Logical "two-way" referral systems to increase timely

access to HTC, ART, TB and MMT are critically needed across all provinces. This involves identifying what client services are available in catchment areas; confirming terms of service, client eligibility, fees, etc; and establishing agreements between referral services and subsequent procedures for tracking referrals and service utilization.

In FY13/COP12, USAID/SMART TA is providing TA to test and/or expand referral systems introduced in Year 2 of the initiative. They include (a) expansion of the ACIS system in Hai Phong and Hanoi; (b) piloting of an OPC transfer referral system in HCMC, Binh Duong and Dong Nai; (c) development of a prison discharge planning and community referral mechanism; (d) development of an automated TB/HIV referral mechanism, to be piloted in Hai Phong and/or Dong Nai; and (e) expansion of PITC capacity building and referral procedures in targeted hospitals.

In the area of MMT, USAID/SMART TA ran trainings in Ho Chi Minh, Dien Bien, Hai Phong, Quang Ninh and Ha Noi on routine HTC for MMT patients and their partners. Key activities now include: (a) review of caseloads to determine if all MMT patients were HIV tested upon admission at SMART TA-supported sites; (b) creation of lists of HIV negative patients eligible for repeated HIV testing every six months; (c) multi-family group education to emphasize the importance of HIV testing and counseling, early ARV treatment, and partner testing; (d) development of methods for sharing limited clinical information (CD4, medications, compliance) between MMT and ART clinics.

By March 2014, the number of MMT patients in SMART TA-supported sites was 5295, of whom 1311 (24.76%) were HIV positive, and 1000 patients were on ART (76.28% of HIV positive patients). Repeat testing amongst HIV negative patients has been implemented in Dien Bien and HCMC. In the past six months, all 1034 HIV negative patients in Dien Bien were retested, with six sero-conversion cases identified (1 in Thanh Xuong and 5 in Muong Ang, supported by the GFATM). In HCMC, 75/135 (55.5%) of HIV negative clients in Binh Thanh clinic were retested, with one sero-conversion case identified. In District 8, HCMC, 76/173 (43.9%) of patients who were HIV negative were retested. None of these individuals was diagnosed as HIV positive.

Collecting the numbers of HIV positive patients that are linked to

HIV care and treatment services is not currently required by the VAAC reporting system. Over the coming semi-annual period, USAID/SMART TA will recommend that nine facilities pilot a referral/liaison data collection system to test its feasibility.

(d) Conduct viral load assessments and provide TA on implementation of Testing Decision 1921.

Lead units: Care and Treatment, SI
Results: Assessment findings and revised program strategies; defined TA role under Decision 1921

Completed Ongoing

In Year 2 of SMART TA, we initiated work on a viral load assessment among pre-ART clients in HCMC. The objectives of the assessment are to (1) determine the utility of viral load testing to profile those individuals at high risk of transmitting HIV to others so intensive prevention interventions can be targeted to them; and to (2) identify those most likely to rapidly progress to AIDS and need early treatment. This assessment now has 600 participants enrolled and is expected to be completed in the last half of Year 3, with results directly feeding into program improvement strategies. We have also completed an ART viral assessment protocol (ART Cascade Completion study), which has passed scientific review, the FHI 360 IRB process, and been submitted for local IRB approval. This assessment among ART clients will help provinces better understand the degree to which clients on sustained ART have suppressed their viral loads. The assessment will commence over the following six month reporting period.

Pay for results

With declining funder resources, it is important to make every dollar or dong count. This means that we must ensure that resources can be directly tied to results; that innovations are introduced with sustainability in mind; that existing interventions can be streamlined whenever possible; and that expenditure or costing data aides GVN decision-making and prioritization.

Over FY14/COP13, SMART TA is emphasizing the following actions:

(a) *Field test individual performance-based incentive models in USAID-supported provinces.*

Lead units: Prevention, SC, Care & treatment (CHBC)
Results: Operationalized individual performance-based systems in up to 12 provinces

Completed Ongoing

As part of USAID/SMART TA's 'community supporter' initiative, we have moved from the provision of implementer monthly stipends to performance-based systems in the majority of SMART TA-supported programming. We are currently trialing four different PBI schemes:

- *Fansipan* (HCMC)– automatic mobile telephone top ups for clients testing for HIV; prizes for implementers for successful case finding and HIV care and treatment enrollment. Between June – November 2013, HIV testing rose dramatically after a single face-to-face contact (from 19% to 68%), and the costs of identifying an HIV positive person simultaneously fell, from $188 USD to $72 USD.

- *Hamlet health worker model* (Nghe An, Lao Cai) – 5,000 VND for each risk assessment performed and entered into mCare system; 100,000 VND for successfully referring HIV positive individual for testing; 100,000 VND for successfully finding

individuals who have not enrolled in care, or have missed pre-ART, ART or MMT appointments. 60,000 VND for successfully referring HIV positive individual's family members for testing. District authorities have found it difficult to implement this scheme through a paper-based system; the mCare case management and PBI system will be introduced to these areas in May 2014.

- *Enhanced outreach approach* (9 PEPFAR focus provinces) – 400,000 VND PBI base for achievement of monthly performance targets; 50-70,000 VND for successfully referring a KP client for newly testing within a 6-month period; 100,000 VND for successfully finding a newly diagnosed PLHIV; and 100,000 VND for enrolling or re-engaging a PLHIV in care. The enhanced outreach approach is now in the field-testing phase, with plans to automate the system by adapting the Fansipan and mCare platforms.

- *CHBC PBI scheme* (Hanoi, HCMC) – Trialed in HCMC and Hanoi, the CHBC PBI strategy includes a fixed allowance combined with a PBI mechanism for staff who exceed the 10-high needs client minimum limit. Over the next semi-annual reporting period, USAID/SMART TA will work to prepare a CBS+ strategy to ensure that there is one unified CBS PBI scheme put forth by USAID/SMART TA.

(b) *Explore feasibility of site performance incentive models.*

Lead units: Care & treatment
Results: N/A in Year 3

Completed Ongoing

Together with individual-level performance incentives, USAID/SMART TA is interested in the feasibility of offering site performance incentives for HIV facilities. Site incentives can reward facilities that reach specified cascade goals and/or improve SMART technical monitoring classification ratings. Site-level performance-based financing may offer alternative ways to improve service system performance that make more efficient use of resources. In conjunction with individual-level performance incentive schemes,

these models may promote better facility-community provider collaboration.

USAID/SMART TA will not introduce performance-based sub-agreements in Year 3, but will examine the feasibility of this approach in Year 4 of the initiative.

(c) *Establish private sector partnerships (or alternative service models).*

Lead units: SC, MMT
Results: Private sector partnership agreements; amount/kind of support; collaboration agreement with Healthy Markets implementer; MMT co-pay models

Completed Ongoing

With the delay in the Healthy Market initiative, USAID/SMART TA has not prioritized private sector partnership work in this first semi-annual period. We plan to collaborate with USAID/Healthy Markets to expand private sector market share of critical commodities for KAPs across the country over the next reporting period.

Since January 2014, SMART TA has withdrawn all running costs for seven MMT clinics operated by the health sector. Despite Hai Phong's strong commitment to MMT programs, fiscal realities require a modest co-pay amount from patients and/or their families. With technical support from USAID/SMART TA, Hai Phong has developed the first co-pay system, approved by the People's Council and People's Committee in December 2013. MMT patients in Hai Phong pay 10,000 VND/day for services (equivalent to 50 US cents/day). The fee is collected on a monthly or quarterly basis. Patients under the government poverty line will receive government subsidies up to 80% for this fee, leaving a patient responsibility of only 2,000 VND/day (10 cents/day).

USAID/SMART TA has conducted a study to measure the effects of the transition from a free service model to a co-pay model in Hai Phong, looking at affordability, drop out rates, and patient satisfaction with clinic services before and after fee introduction. Baseline data was collected in February 2014 with >90%

participation. We will analyze 3 month, 6 month, and 12 month surveys and report on the preliminary results in the next reporting period.

(d) *Conduct and/or provide TA on analyses of service unit costs, expenditures and programmatic impact.*

Lead units: SI, Finance
Results: Expenditure data included in programmatic analysis reports; innovations strategies illustrate unit costs vis-à-vis conventional interventions; literature reviews; costing assessment(s)

Completed Ongoing

In FY14/COP13, USAID/SMART TA has initiated detailed expenditure analyses for USAID/SMART-TA supported sites and interventions. These exercises analyze FY12 and FY13 expenditure data and performance across SMART-TA supported sites/interventions and compare expenditures to overall productivity and key outcomes in an effort to help provinces make more strategic and sustainable programmatic and resource allocations. A site expenditure analysis carried out for the HIV treatment program showed that the average unit expenditure per adult on ART (ARV drugs not included) was US$45.6 in FY12. The second expenditure analysis — this time focused on HIV testing and counseling in 34 SMART-TA supported HTC sites - showed median expenditures per one HTC first time identified positive client at US$176.1 in FY13. Of particular interest was the correlation between performance and cost, with four service sites recording both the highest total costs and the lowest client uptake (see Figure 5).

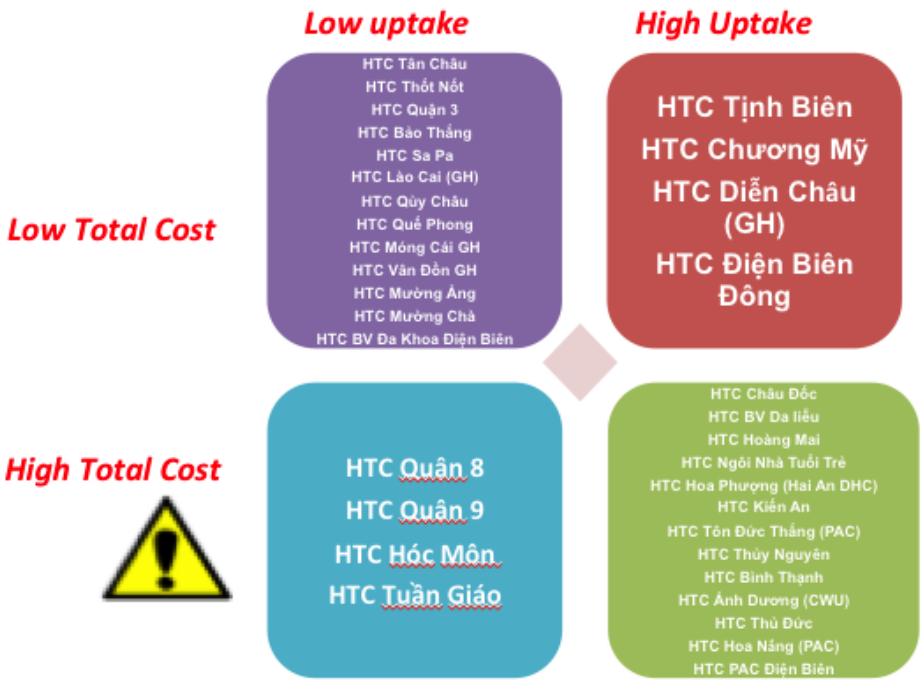


Figure 5|HTC expenditure and service data

USAID/SMART TA and its partners are using this data to make programmatic efficiencies that move towards greater country ownership. In the coming semi-annual period, USAID/SMART TA will carry out an HIV prevention expenditure analysis and use all expenditure data to analyze expenditures across the HIV cascade.

OBJECTIVE II | Strengthen GVN and CSO technical capacity

USAID/SMART TA strengthens technical capacity and promotes country ownership of the HIV response by identifying, developing, implementing and evaluating feasible, sustainable TA models/systems and technical assistance efforts. We:

1. Design, implement and evaluate TA services and systems including both "pull" and "push" efforts in Vietnam.
2. Develop, support and evaluate local technical assistance efforts.
3. Expand and enhance capabilities to provide strategic information, monitoring and evaluation, and research to improve services and systems in Vietnam.

In FY14/COP13, USAID/SMART TA works to operationalize provincial and national TA networks and implement a push and pull TA system. Our efforts are focused on the following task areas:

(a) *Design and implement an effective "pull" TA system.*

Lead units: TACHSS, SI
Results: Pull TA case management system; training and mentoring curricula; Pull TA reports and resources

Completed Ongoing

Over the semi-annual period, USAID/SMART TA developed the parameters of a customized software system that will allow us to manage and track the technical assistance we provide through both push and pull mechanisms. Among the information that this system will track includes (a) TA type and method; (b) TA deliverables and indicator progress; and (c) TA provider and recipient. USAID/SMART TA has initiated a request for proposals and expects to have an operational platform during the upcoming reporting period. In the interim, SMART TA's TACHSS unit receives "pull" TA requests from partners (through face-to-face or virtual mechanisms) and then analyzes, triages and directs them to relevant technical teams.

(b) *Design and implement at least 5 "push" TA initiatives.*

Lead units: TACHSS, all technical units
Results: "Push" TA strategies and implementation plans

Completed Ongoing

In Year 2, the primary push TA priority was to introduce the cascade model. Although there is still much more to be done to establish it is the default national framework for assessing the performance of the HIV service system, it has already gained the support of VAAC, NIHE, CDC, the Committee 50 and many provinces. This fiscal year, USAID/SMART TA continues to apply the cascade model to new provinces and integrate it into our regular TA offerings. We also are emphasizing five "push" TA initiatives that can lead to substantive improvements in service systems capabilities, quality and performance via evidence-based practices and emerging technologies relevant and feasible for Vietnam.

Our year three push TA priorities are:

- **Application of the Cascade framework** – Over the semi-annual period, USAID/SMART TA drafted the "Guidelines for Data Collection and Interpretation of the Cascade Model," together with an excel-based data entry program and auto-generation graphics function. These guidelines have been submitted to PEPFAR for review and are being updated now to incorporate the MER indicators. In November 2014, Caroline Francis and Gary West organized and facilitated a special ICAAP satellite session that focused on improving the HIV cascade of services across the Asia-Pacific region. The satellite session brought together experts from WHO, NCHADS (Cambodia), UNDP and NATURE organization (India) to discuss how the cascade conceptual framework has been applied in their country settings. Following this session, FHI 360 was asked to contribute technical comments on the proposed WHO cascade indicators for the region, which we provided in January 2014.

  In addition to presenting and advancing the HIV cascade conceptual framework, we have also developed and used cascades for TB/HIV and MMT. On January 5-6, 2014, Gary

West presented the MMT cascade of services to the Office of the Government, Committee 50 and numerous national and provincial government institutions. The meeting culminated with an aggressive push for MMT scale up. As of February 2014, 41 provinces have requested official approval to open 161 new MMT clinics or satellite services in 2014, 48 new clinics in 2015, and eight clinics from 2016-2020.

- Introduction of **new approaches** that increase the number of PLHIV newly testing HIV positive and the number newly initiating ART. These new approaches include (a) the enhanced outreach approach; (b) the hamlet health worker model; (c) Fansipan Challenge; (d) social media "Test HCMC" approach for MSM; and (e) the reconfigured CHBC approach, which segments PLHIV clients, reduces the CHBC workforce, and includes a performance-based incentive component.

- **Reducing loss to follow up** in CoPC service systems and increasing the number sustained on ART and achieving viral suppression. In addition to applying performance-based incentive schemes for successful LTFU case finding (community-based programming) and retention in care into our SMART technical monitoring approach, USAID/SMART TA has developed (a) a "red flag" tool that provides early warning indicators for facility-based pre-ART and ART clients who are at risk for LTFU and (b) a combined retention strategy and SOP to reduce LTFU. In the coming semi-annual period, we will introduce tailored SMS retention messaging for PLHIV and procedures to track clients that transfer between facilities (e.g. in HCMC).

- **Information Technology Communications (ICT)** – over the course of the semi-annual period, USAID/SMART TA has worked with CHAI to trial the ACIS SMS referral system across more than 40 outpatient clinics and HIV testing facilities in three provinces. We have developed the mCare case management and PBI system which is currently being field tested in Nghe An province, and the Fansipan ICT system that is in the process of scale up across seven provinces. We have contracted a Canadian IT firm to customize the Open Source Clinical Application Resource (OSCAR), a dual language electronic medical record for MMT service reporting and client tracking. We are also developing a mobile learning and performance support system for community-based health workers that is planned to launch during the next reporting period.

- **Service delivery innovations** – USAID/SMART TA will play a key technical role in the roll out of the mountainous "reach, test, treat and retain" model (to be introduced over the next reporting period). To date, we have carried out rapid assessments in three of the 16 targeted provinces and are currently providing TA in preparation for the expanded initiative.

(c) *Develop and implement blended and technology-mediated learning strategy tracked through the SMART TA database.*

Lead units: SC, TACHSS, MMT, SI
Results: Blended learning strategy documentation; 2 online platforms; SMART TA capacity building database; online training tools (e.g. 10 modules for drug use and MMT services)

Completed Ongoing

Blended learning and related capacity building offers a mix of online, mobile and face-to-face instruction for in-service, mentoring and CME accreditation needs. This expanded mix of methods will enable us to select the learning approach and methodology most suitable for specific audiences and situations.

The website www.dieutrimmt.vn http://www.dieutrimmt.vn offers valuable resources for MMT patients, families, and clinicians. A comprehensive, user-friendly interface has been recently created, including the addition of audio-visual materials (especially video clips and audio highlights). MMT clinicians periodically receive e-mail broadcasts each time there are new additions to content areas.

Over the reporting period, we developed an interactive map of MMT resources to facilitate cross-referrals and to educate the public about local resources. Fifty-three video lectures were completed and launched. Given the rapid scale-up of the MMT program nationwide, coupled with the limited number of national mentors, we believe that an e-learning approach is a cost-effective way to meet high training demands, especially training for HTC and ARV staff in newly integrated clinics.

Over the next semi-annual period, a three-month case study will be launched in one MMT clinic gain further insights on how these online tools are being used and how the interface may be strengthened. We would like the current website to be improved and better promoted so as to become a routine source of timely information, knowledge and experiences about MMT for general public and MMT professionals. While VAAC will host this knowledge hub in future years, it will continue to require outside support for materials development and regular maintenance. HAIVN and HMU are working with us to develop online CME courses that could be used to meet new national CME requirements.

We are also collaborating with HAIVN to conduct monthly web-based seminars **(webinars).** The key feature of webinars is their interactive element, allowing interaction between the presenter and the audience. With just a computer and a good internet connection, any MMT professional is able to join the webinar for a presentation, lecture or discussion. This e-learning tool is an effective way to enhance the access of MMT professionals to up-to-date information, new knowledge and to share clinical experience.

Over the semi-annual period, USAID/SMART TA has provided technical and financial assistance to support the creation and roll out of **VAAC's knowledge hub portal** (Figure 6). This online platform – targeting service providers, clients, and others associated with delivery of the HIV response – contains (a) HIV service promotional information (through videos, print materials, etc); (b) service location data utilizing Google Maps; and (c) and a resource library for implementers (e.g. curricula, communications tools, etc). We are currently in Phase 2 of this 3-phase initiative whereby the focus is on compiling and standardizing the content for the library, and developing the demand creation strategy. It is expected that the portal will be operational over the following reporting period.

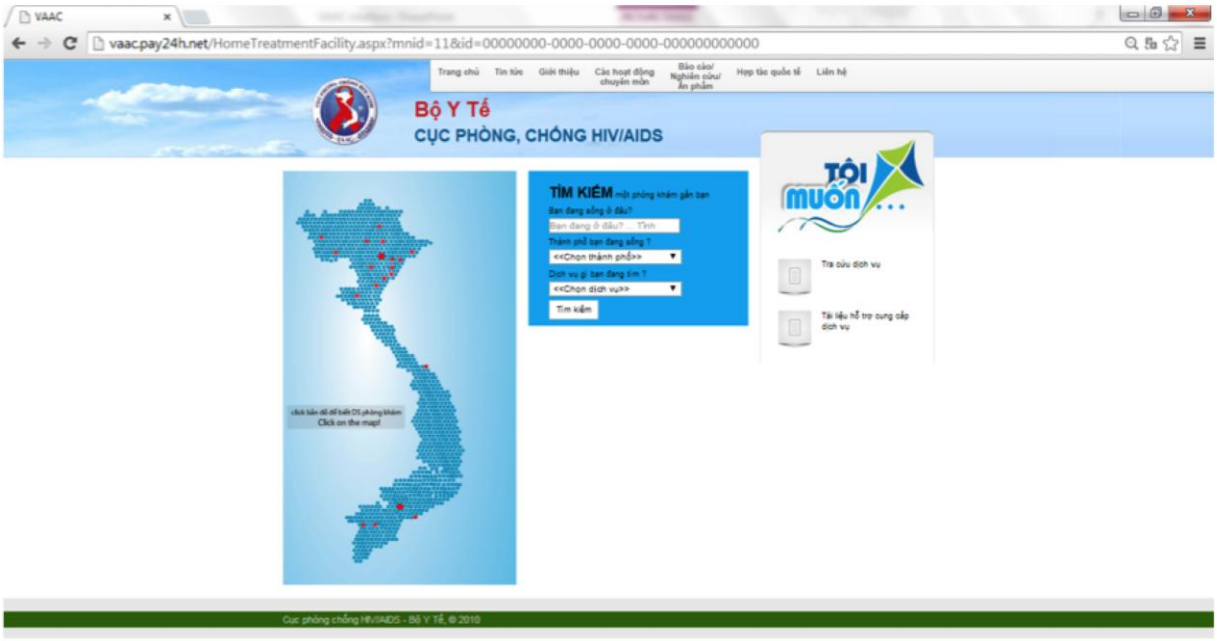


Figure 6| VAAC service delivery interface

(d) *Establish a sustainable network of well-trained, experienced provincial and national TA providers.*

Lead units: TACHSS, MMT, Prevention
Results: TA network selection criteria and process documents; TA training Modules 1-3; TA reports; GVN documentation on TA roles/responsibilities/ sustainability

Completed Ongoing

While PAC/PHS and other provincial and national institution staff are currently providing technical assistance to district and commune counterparts, very few have been formally trained on how to identify technical needs or provide, monitor and evaluate technical assistance – in short, how to be TA providers or to coordinate TA efforts in Vietnam. Also missing is the creation and support of sustainable network(s) of TA providers at the national and provincial levels. SMART TA has thereby focused our efforts during the first six months of FY14/COP13 on (a) field testing and rolling out an introductory TA provider training package; and (b)

selecting and supporting TA networks in the areas of HSS, MMT and enhanced outreach.

TA Training Module 1 - USAID/SMART TA refined and field-tested (with SMART TA technical staff) an introductory training course on "How to be an effective TA provider in Vietnam." The three-day experiential program focuses on (a) the science of technical assistance; (2) TA classification systems, TA delivery methods and models; (3) communications skills building; and (e) applying learning in real-life provincial settings, using case studies developed for the Vietnam context. Following field-testing of the curriculum among 25 SMART TA technical staff in February 2014, we conducted a learner analysis of individuals nominated to be members of provincial TA networks (see below). Forty-five learner responses were incorporated into the further refinement of the training materials; from 22-24 April 2014, we conducted the first of two provincial training sessions for 25 TA network representatives from Lao Cai, Dien Bien, Ha Noi, Nghe An and Hai Phong. This training was very well received, with high ratings from all participants.

The next training session – for Southern TA network members – will take place in May 2014. All training participants are tasked with applying their knowledge by introducing the cascade conceptual framework into their respective provinces. USAID/SMART TA will work closely with network members as they undertake this work and have also established an "I love TA" community of practice on social media where TA providers will share their experiences and learning.

TA Network(s) – Over the reporting period, we worked with provinces (PAC/PHS) and national institutions to identify and recruit members of provincial TA networks. Potential members were nominated based on their current role as TA providers and the willingness of the province or institution to allow them to participate in the network. All nine PEPFAR-focus provinces participated in this exercise and nominated 120 individuals to participate in provincial TA provision. These individuals represent all CoPC technical areas, management and M&E. They hail from both GVN institutions and from SOs. As outlined in each sub-agreement, USAID/SMART TA will provide funding for training, mentoring and for an agreed-upon portion of their time to work on push TA initiatives in and outside of the province when needs and

opportunities arise. Continuing from the introductory TA training, we will support these individuals to provide/coordinate TA within their province(s); we also will work with targeted provinces to institutionalize TA and strengthen TA delivery mechanisms.

Within these networks are thirty-nine men and women who have been identified as enhanced outreach master trainers. While most will provide TA to their respective provinces, nine individuals will form regional "master" TA teams and travel across provinces to support enhanced outreach efforts. "This strategy is very new and difficult", expressed By Tuan from the Hanoi PAC, "but we are determined to pursue the enhanced outreach approach. We are ready to challenge ourselves and to climb this mountain with support from FHI 360."

In the area of MMT, SMART TA is collaborating with VAAC to strengthen the mentorship system. VAAC issued a letter to provinces requesting participation in technical assistance efforts using local MMT clinic experts. In April 2014, we conducted local mentorship trainings to 80 new mentors and established 22 MMT practicum sites across 12 provinces.

Together with VAAC, we improved clinical mentoring training materials, making tools more practical and efficient. Lectures have been reduced, and time for practice, for demonstrations, and for role-playing has been increased. Two-day classroom mentorship training is followed by practicum trips that pair new mentors with SMART TA technical staff in field settings. We believe that mentors will play a critical role in, not only scaling up MMT services to reach national targets, but also in ensuring the quality of services and sustainability of TA provision.

(e) *Develop portfolio of CoPC service delivery and intervention models in Vietnam.*

Lead units: TACHSS
Results: New service models identified, assessed for utility, and disseminated through provincial/national TA networks

Completed Ongoing

Vietnam's diverse geography and the varied local situations challenge the development of an effective national response to the HIV epidemic and the design of service systems. There are remote mountainous, rural areas in the north and central, large urban areas in the north and the south, very lengthy coastal areas, and borders with three countries: China, Laos and Cambodia. Some provinces are comparatively wealthy; others are very poor. There is a wide range of situations in which HIV prevention, care and treatment services must be delivered effectively and achieve high coverage among multiple KPs. Under these circumstances, there needs to be an expansive menu of proven effective service delivery options that can be delivered efficiently in specific contexts. During Year 3, USAID/SMART TA is expanding its TA portfolio and testing new service delivery models potentially suitable and feasible for different situations in Vietnam. These include (a) PMTCT B+, (b) CoPC interventions in closed settings; (c) the enhanced outreach approach; (d) the hamlet health worker model; (e) interventions utilizing mobile technologies and social media (e.g. Fansipan, mCare, ACIS, TestHCMC); (f) integrated service provision; and (g) the mountainous model.

(f) *Identify sustainable homes for TA systems.*

Lead units: TACHSS
Results: TA systems assessment, TA network membership roster, National Training Center operational plan and training materials, MoLISA training program strategy and tools, TA systems review

Completed Ongoing

USAID/SMART TA's overarching goal is to design and operationalize effective, efficient, affordable HIV service delivery and TA systems feasible in Vietnam and to sustain them through local ownership and management. A key factor in sustainability is to identify potential homes within the GVN structure that can assume TA management and operational responsibility and to collaborate closely with these institutions to develop the TA models. It is clear that provinces must first take the lead for operational management and use of the cascade framework to monitor the overall performance of local service systems for both HIV and drug use.

However, provinces will need strong support and coordination from VAAC and other national institutions.

Given the current structure of the Vietnam health system and the roles and functions of national institutions, it may not be possible to identify a single home. No institution yet has the mandate to coordinate TA services across the multiple national institutions or across the country. The only viable option may be multiple homes that collaborate and coordinate effectively and efficiently. It currently appears that some combination of VAAC, NIHE, MoLISA and potentially other institutions will need to assume management of the project TA system. Currently none of these bodies has sufficiently broad authority, topical expertise or experience in coordinating other Vietnamese institutions to lead a comprehensive TA system. For TA on drug use prevention and MMT services, coalitions of institutions in Hanoi (NIMH/HMU/Bach Mai) and HCMC (HCMC Medicine & Pharmacy University) can support national training centers. The formation of a national TA network is an appropriate first step in creating a national home for TA services as at least management of the network could be transitioned to a single home within the national Government, and even if it is not able to coordinate all the HIV TA services, it could still perform many of the essential functions. Nevertheless, USAID/SMART TA will continue to evaluate options for TA home(s) in Vietnam, with the objective of establishing one or more by the end of Year 5.

(g) *Support capacity building and strategy development efforts for a coordinated and sustainable HIV response.*

Lead units: TACHSS, all technical units
Results: 739 health workers successfully complete an in-service training program; 598 community health and paraprofessional social workers successfully complete an in-service training program; Number/Kind technical inputs for policy documents, SoPs, master plans, etc.

Completed Ongoing

Over the semi-annual period, USAID/SMART TA conducted numerous trainings, including:

- *Basic MMT training* for 30 representatives of five medical schools and mental health institutions
- *HIV case finding orientation* for 130 hamlet health workers in Nghe An and Lao Cai provinces
- *Sex worker harm reduction* training for 200 secretaries of Youth Unions across 10 provinces
- *Enhanced Outreach Training of Trainer* courses for
- *PMTCT B+ orientation* for 315 health care providers in Nghe An province
- *MMT local mentorship* training for 80 new clinical mentors
- *HIV testing and care and treatment training* for CoPC service provision in prisons (100 persons)
- *How to be a TA provider in Vietnam* for 25 members of local TA networks

USAID/SMART TA also prepared and/or contributed to various SOPs and guideline documents, including (a) six SOPs that cover key MMT service practices such as intake, patient assessment procedures, urine testing, staff cooperation; service referrals and MMT satellite dispensing; (b) MMT case manager guidelines for group education; (c) national HTC guidelines; (d) PMTCT B+ protocol; (d) enhanced outreach and mCare protocols; and (e) the strategic framework for CoPC service provision in closed settings. Other examples of technical tools development are highlighted elsewhere in this report; the numbers of people served through TA is further detailed in Annex 2.

(e) *Apply SMART technical monitoring approach.*

Lead units: All technical units, coordination by SI and TACHSS
Results: SMART technical monitoring strategies, protocols and tools; implementation and mentoring plans; site/intervention classification upon baseline and at end of fiscal year; SMART monitoring reports and QI plans; level of effort of SMART TA staff commensurate with site classification needs

Completed Ongoing

In the first half of FY14/COP13, USAID/SMART TA developed and initiated our SMART [technical] monitoring approach (in the process of being renamed). This broad strategy – initiated through the care

and treatment unit and expanded across the MMT and HIV testing and counseling sectors – is a key transition tool. It can help us: (1) rapidly identify service sites that are ready for reduced oversight and/or transition; and (2) target TA to real issues that, if resolved, will support the site to become more productive, attain better overall service quality, and work towards sustainability.

USAID/SMART TA's care and treatment team developed a standardized monitoring system to facilitate transition of care and treatment sites and identify TA needs. It includes 10 core indicators and associated data collection tools. During the reporting period, 24 SMART TA-supported care and treatment facilities underwent a baseline assessment of relevant domains required for more sustainable system performance: (1) pre-ART/ART service delivery; (2) case management; (3) data collection; (4) ARV and OI supply chain; (5) laboratory capacity; (6) OPC structure and access; and (7) human resource capacity. Based on the baseline assessment, the highest needs for TA across most facilities were case management and data collection procedures. USAID/SMART TA categorized these sites as "improving" (currently performing below standards) or "effective" (meeting or exceeding standards), based on the data availability of a selected set of national quality indicators (see Figure 7). Fifteen sites were assessed to be improving and eight facilities were considered effective.

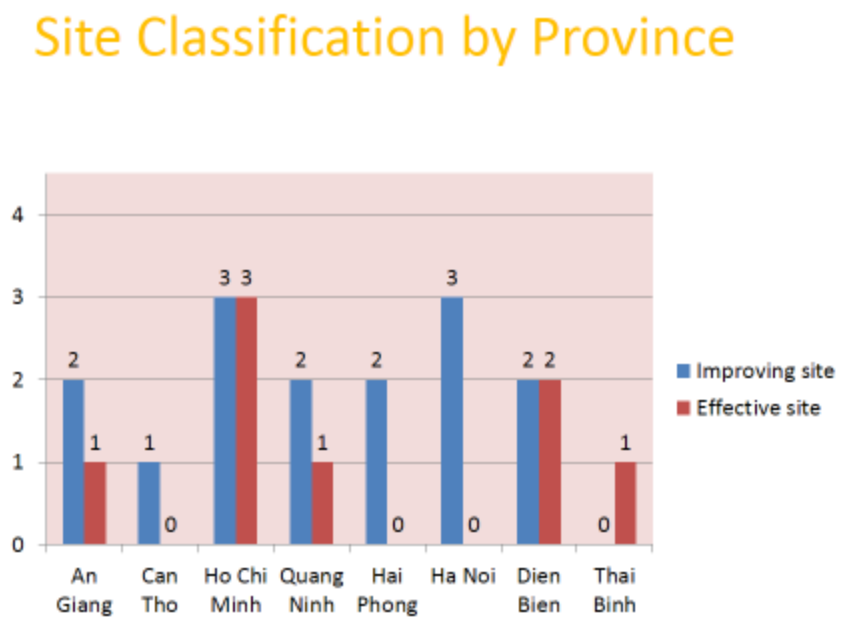


Figure 7| **Baseline SMART technical monitoring at 24 facilities**

USAID/SMART TA is using this monitoring data to tailor technical assistance provision in terms of both frequency and intensity at the delivery site levels. We will support short quality improvement cycles and monitor system-based improvements on a bi-annual basis. Over the upcoming semi-annual period, SMART TA will allocate additional technical assistance resources towards improving sites that have the greatest service delivery volume, and data and program management needs. For effective sites, innovative practices, interventions and service models will be applied so that sustainable sites can be transitioned to local management as feasible.

This technical monitoring approach is also being adapted to HIV testing and counseling, MMT, HIV prevention, and technical assistance evaluation. As part of the SMART technical monitoring approach, for example, we are reviewing and revising key MMT indicators. We have recommended some minor simplifications for the national data collection system, and are introducing the concept of Gold Standard Indicators to determine when a MMT clinic may be considered stable. We have further recommended the addition of six new indicators to focus and orient MMT clinics towards HIV care, with a special emphasis on developing referral/liaison partnerships between MMT and ART Scoring is based on the achievement of

these measures (see Table 1).

MMT Clinic Scoring	Level of Development	Nature of Technical Assistance
1. Developing Program	New or Failing to meet baseline procedures and measures	Push TA
2. Stable Program	Meets 6 Gold Standard Measures	Pull TA
3. Model Program	Advanced performance, Source for mentor staff	Pull TA & Mentor Trainings

Table 1| MMT clinic scoring criteria

(h) *Strengthen "one" national M&E system.*

Lead units: SI
Results: Provincial cascades; GVN-supported M&E positions/ departments; DQA/SMART monitoring plans and reports; M&E tools; quarterly data feedback documents; QI strategies

Completed Ongoing

In FY14/COP13, USAID/SMART TA emphasizes efforts to improve M&E capacities, tools and systems. As part of the joint provincial planning process, provinces identified one M&E position (or department) that can coordinate and lead M&E efforts across the HIV response. USAID/SMART TA is focusing our capacity building efforts on this person(s) to ensure that they can generate and interpret cascades, lead DQAs, participate in SMART monitoring visits, etc.

We've also provided TA to streamline data collection tools as per data flow processes and critical cascade performance indicators. Together with the prevention team, we created new outreach M&E forms to replace outdated and ineffective prevention tools. We worked closely with VAAC to prepare and finalize MMT M&E tools and the national training package that is being rolled out beginning in April 2014. We provided TA to finalize the national guidelines on data quality assurance, updated the DQA protocol, and created care

and treatment pre-ARV and ARV e-logbooks to minimize the reporting burden on care and treatment facility staff across SMART TA-supported sites.

Following application of HIVQUAL Round 4 in targeted care and treatment sites, USAID/SMART TA highlighted five problematic indicators where data variance was as high as 70%. Together with the HIVQUAL technical working group, we conducted a mid-round assessment to evaluate progress on these indicators and to support facilities/provinces to develop and implement QI plans. We also worked at the national levels to revise the indicators and data collection software for HIVQUAL Round 5, which is expected to commence during the next semi-annual reporting period.

To facilitate and support data use, USAID/SMART TA continues to provide quarterly data feedback, both to our technical teams, as well as to provinces, districts and facilities. Data feedback provides a mechanism to (a) highlight programmatic successes, challenges and gaps; (b) identify programmatic priorities; and (c) develop time-bound, action plans for quality improvement.

(i) *Design and/or provide TA for research that will lead to substantial improvements in service and intervention implementation.*

Lead units: SI
Results: Number/kind/findings of research studies, protocols, assessments

Completed Ongoing

USAID/SMART TA gives priority to leading and supporting operational research, surveillance and epidemiologic studies that are clearly linked to improving program and service system outcomes.

Over the reporting period, we worked closely with research firm TNS to complete the study on **Staff Time Efficiency in Methadone Clinics**. The overall goal of this study is to explore staff time spent for service delivery at different positions and subsequently to calculate and simulate minimum staff needed for different MMT treatment modalities. Recommendations were given

to improve staff efficiencies, including different visitation schedules for first-time versus continuing clients, and the provision of group counseling (rather than individual counseling measures). First drafts of the report were completed in Nov 2013, with the final version of the report completed in early 2014. A dissemination workshop will be scheduled in quarter 3 of FY14/COP13.

USAID/SMART TA – in partnership with VAAC and a specially convened advisory committee – is working with DEPOCEN to finalize the protocol and prepare the desk review as part of the **National Outreach Assessment**. This task will provide information on current practices and approaches to planning, managing, implementing and monitoring HIV prevention outreach for key populations. The review will identify promising practices and lessons learned across HIV prevention programming and will inform the development of national HIV prevention outreach guidelines and standards. The promising practices will be identified based on a set of criteria and methods that will be developed before the analysis is conducted. However, the situation analysis will not assess cost-effectiveness or impact of current outreach delivery models. The protocol has been submitted to the relevant IRBs. This task will be completed by Sept 2014.

We are currently working with various partners (e.g. CDC, VAAC, NHIE, etc) to finalize the following manuscripts: (1) Sampling Males who Inject Drugs in Haiphong, Vietnam: a Comparison of Simultaneous Time-Location and Respondent-Driven Sampling Methods; (2) Trends of HIV among Men who have Sex with Men in Ho Chi Minh City; and the (3) PLHIV late entry assessment. These manuscripts are being reviewed and will soon be submitted to peer review journals, to contribute to the evidence-base in the country.

OBJECTIVE III | Transition financial, administrative and technical ownership of CoPC services

USAID/SMART TA works to transition a minimum of 40% of financial, administrative and technical functions and direct support to the GVN, as feasible, based on a systematic assessment of the willingness, capabilities feasibility, and readiness to sustain such functions and services.

Transition, within the Vietnamese context, can be described as "restoring responsibility and support for service delivery to the GVN and SOs, while ensuring the quality, coverage and sustainability of services" (HCMC PAC, December 2012).

In Year 3, we are working towards this goal through (i) joint provincial planning and implementation; and (ii) financing advocacy efforts. Our primary achievements over the semi-annual reporting period are:

(a) *Develop a collaborative approach for the development, implementation and oversight of provincial sub-agreements.*

Lead units: TACHSS
Results: Sub-agreements finalized and operational by 1 January 2014. Sub-agreements illustrate GVN cost share, reflect HRH plans, respond to cascade leaks, and reduce administrative burden

Completed Ongoing

USAID/SMART TA supports 14 sub-agreements with eleven provinces currently receiving financial support. Our process of sub-agreement development and negotiation were modified over the semi-annual reporting period to ensure that agreements responded to provincial priorities across the CoPC cascade, and reflected our values of open partnership, gender sensitivity and collaboration. Provinces were supported to analyze their CoPC service cascades, review provincial targets/plans, develop sustainable HRH strategies, identify their proportion of cost-share, highlight their TA needs, and engage in collaborative planning exercises across funders.

USAID/SMART TA developed a list of core and innovative activities, and encouraged provinces to select activities that corresponded to their needs. Intensive support was provided to provinces over the first quarter of FY14/COP13 to complete the sub-agreement narratives and budgets, and to set appropriate program targets.

USAID approved these sub-agreements in January 2014; contracts are operational until at least 31 December 2014, in keeping with the GVN fiscal year.

Following the finalization of sub-agreements, USAID/SMART TA has conducted collaborative briefings in each PEPFAR-supported province to review and enhance sub-agreement implementation plans. SMART TA's provincial sub-agreement coordinators regularly communicate with provinces to monitor implementation progress and quality, and identify priority push and pull TA needs.

(b) *Conduct rapid assessments in 3 new provinces.*

Lead units: TACHSS
Results: Rapid assessment plans and reports

Completed Ongoing

USAID and SMART TA have identified preliminary criteria by which to identify provinces for targeted, time-bound TA. These criteria include: (i) substantial epidemics are occurring in under- or poorly-served areas; (ii) cascade and other analyses (e.g. service mapping) have clearly identified service deficits and/or areas for improvement; (iii) provincial authorities display high commitment to improving/expanding services and/or responding to service "leaks"; (iv) resource and/or local capacity deficits severely constrain improving or expanding services without USAID/SMART TA financial and technical support; (v) province is committed to using the cascade framework to monitor short and long-term impacts of financial and technical assistance; (vi) province is committed to sustaining programs and services (e.g. local staffing, financial oversight) once short-term financial assistance has ended; and (vii) other donors, such as GFATM, CDC/VAAC and HAARP, also support assistance from USAID/SMART TA.

Using the standardized RAR protocol developed in Year 2, USAID/SMART TA will carry out rapid assessments in two additional provinces. TA plans will be developed to respond to gaps, issues, or needs identified during the assessment process. Over the course of Year 3, we will monitor implementation of the plans and support semi-annual cascade performance reviews and consultations across provinces receiving TA support.

Two provinces tentatively prioritized for RAR visits/analyses are Thai Nguyen and Thanh Hoa. Over the coming semi-annual period, USAID/SMART TA will review the epidemic situation and service gaps in these provinces, and as needed, will carry out visits that identify key TA priorities.

USAID/SMART TA has also carried out RAR visits in targeted provinces that currently receive USAID assistance. In November 2013, we supported An Giang to identify gaps and outline priority actions in their provincial response. Of key concern in the province were the low HIV testing rates among key populations and their partners and the high mortality rates of PLHIV in the CoPC system. Actions – outlined in the An Giang sub-agreement -- included areas where SMART TA can provide financial and technical support to accelerate program and service improvements in the short term (e.g. expansion of initiatives to increase testing) and to identify areas where SMART TA can provide TA in the long term (sustainable phase) that strengthens the Provincial Master Plan for HIV Services.

Most recently, we completed our final RAR in Quang Ninh; the results of this assessment are currently being compiled.

(c) *Track and monitor GVN financial contributions at all levels in provinces receiving USAID/SMART TA support.*

Lead units: TACHSS, Finance, MMT
Results: Proportion of GVN cost share/year

Completed Ongoing

Over this reporting period, USAID/SMART TA asked provinces to provide information on the types/amount of local contributions that are being made to support sites, services and programs receiving USAID/SMART TA assistance. We provided training to provinces on how to categorize and report the contribution. We also hired an independent company to assess GVN contributions with respect to infrastructure support. Provinces will now send cost-share reports, together with financial reports, to USAID/SMART TA. Together with expenditure analysis data, we will use this information to identify and track local investment across the HIV response.

The cost share for the last 6 months is $348,637 USD. Sub-agreement expenses during this period were $957,924, while total SMART TA expenses were $4,065,812. The cost share rate averaged 36% of the sub-agreement expenses and 8.6% of the total expenses.

In the area of MMT, USAID/SMART TA worked closely with our GVN partners to transition human resources in a phased manner. Table 2 highlights significant transition of methadone maintenance treatment (MMT) human resources and operational costs to the GVN in all 20 MMT clinics currently supported by SMART TA.

The paired graphs (Figure 8) below similarly display the transition of staff salaries from USAID/SMART TA to the Government of Vietnam between October 2011 and January 2014. USAID/SMART TA support decreased from 162 to 43 full-time contract employees, a 73.4% reduction. The percentage of MMT staff supported by the GVN in 20 MMT clinics in 2014 is now as high as 80%. From January 2014, Hai Phong, HCMC, and Can Tho have 100% government-paid staff.

Figure 8| **Transition of MMT human resources (2011-2014)**

Table 2| **MMT human resources comparison (2011-2014)**

MMT Human resource comparision between 2011 and 2014

No	Province/city	Names of MMT Clinics	Oct-11			Jan-14		
			Full-time equivalent (FTE) Government	FTE contract (Government paid)	FTE contracted (SMART TA paid)	Full-time equivalent (FTE) Government	FTE contract (Government paid)	FTE contracted (SMART TA paid)
1	Hai Phong	Lê Chân	0.5	0	11	0.5	11	0
2		Thủy Nguyên	1	0	9	1	9	0
3		Ngô Quyền	0.5	0	8	0.5	8	0
4		Hải An	0	0	9	0	9	0
5		Hồng Bàng	0.5	0	8	0.5	8	0
6		Dương Kinh	1	0	7	1	7	0
7		An Hưng	1	0	7	1	7	0
8		Xã Hội Hóa	0	9	0	0	9	0
	Subtotal		4.5	9	59	4.5	68	0
9	Quang Ninh	Vân Đồn	1	0	20	4	4	11
	Subtotal		1	0	20	4	4	11
10	Dien Bien	Thanh Xương	1.5		9	4.5		8
11		Tuần Giáo	8		5	5.7		4
	Subtotal		9.5	0	14	10.2	0	12
12	Can Tho	Ninh Kiều	0.5		11	9.5	2	
13		Cái Răng	0.5		11	9.5	3	
	Subtotal		1	0	22	19	5	
14	HCMC	Quận 8	1.5		12	8.5	5	
15		Bình Thạnh	3.5		10	4.5	8	
	Subtotal		5	0	22	13	13	0
16	Ha Noi	Đống Đa	0.5		13	4		6
17		Sơn Tây	1		12	1.6		5.4
	Subtotal		1.5	0	25	5.6	0	11.4
18	Bac Giang	Bắc Giang				2.5		8.5
	Subtotal		0	0	0	2.5	0	8.5
19	Quang Tri	Quảng Trị				10	4	0
	Subtotal		0	0	0	10	4	0
20	Lao Cai	Lào Cai						
	Subtotal							
	Total		22.5	9	162	68.8	94	42.9

(d) *Provide TA on the extension of health insurance coverage in targeted CoPC sites.*

Lead units: TACHSS
Results: Health insurance programming expansion plan; health insurance provided to PLHIV in additional targeted sites

Completed Ongoing

USAID/SMART TA continues to pilot a health insurance model in Ho Chi Minh City. Over the last six months, the HCMC PAC, District 8 and Thu Duc District Preventive Medicine Centers conducted training on the Law of Health Insurance for targeted districts and

communes; collected health insurance card information from PLHIV; assessed six communes' capacity to implement the health insurance model; and examined health insurance payment mechanisms in three communes. Between January – March 2014, 10 PLHIV – or 8.5% of all patients – presented at the commune health station for examination of opportunistic infections. We are working with the HCMC PAC to develop strategies that increase the number PLHIV visits at commune health stations. Over the next reporting period, we will synthesize lessons learned across health insurance pilots in HCMC and An Giang and introduce proven strategies to other targeted provinces.

(e) *Provide scientific evidence on global best practice and lessons learned to inform national and provincial policy discussions and decisions.*

Lead units: SI, all technical units
Results: Number/kind of literature reviews and policy papers

Completed Ongoing

Over the course of FY14/COP13, USAID/SMART TA works to ensure that policy discussions and decisions increasingly reflect the most up-to-date scientific evidence, research findings, global best practices and Vietnam program experience. We have prepared literature review analyses on ART effectiveness in developing countries (including Vietnam) and provided reviews of the global evidence on MMT effectiveness as a key HIV intervention. USAID/SMART TA also has initiated detailed expenditure analyses for USAID/SMART-TA supported sites and interventions. These exercises analyze FY12 and FY13 expenditure data and performance across SMART-TA supported sites/interventions and compare expenditures to overall productivity and key outcomes in an effort to help provinces make more strategic and sustainable programmatic and resource allocations. A site expenditure analysis carried out for the HIV treatment program showed that the average unit expenditure per adult on ART (ARV drugs not included) was US$45.6 in FY12. The second expenditure analysis — this time focused on HIV testing and counseling in 34 SMART-TA supported HTC sites - showed median expenditures per one HTC first time

identified positive client at US$176.1 in FY13. USAID/SMART TA and its partners can use this data to make programmatic efficiencies that move towards greater country ownership. In the coming semi-annual period, USAID/SMART TA will carry out an HIV prevention expenditure analysis and use all expenditure data to analyze expenditures across the HIV cascade.

(f) *Assist VAAC and other national institutions to advocate for increased ARV and methadone financing.*

Lead units: TACHSS, Care and Treatment, MMT
Results: National ARV financing proposal; number/kinds/outcomes of ARV financing efforts

Completed Ongoing

In November 2013, USAID/SMART TA supported the Advisory Board of Committee 50 to conduct a workshop on sustainable ARV financing for a wide range of participants from the Government Office, Advisory Board, Ministry of Health (VAAC, Health Insurance Department, Drug Administration), Ministry of Finance, MOLISA, Vietnam Social Security, and international organizations (e.g. UNAIDS, PEPFAR, CHAI, etc.). The workshop presented global evidence on ART efficacy and cost effectiveness. Participants reviewed and analyzed GVN budget allocation policies and ARV purchasing practices. They shared and analyzed different regional models of sustainable ARV financing – including those in Thailand, Malaysia and Indonesia. Participants concluded the meeting with recommendations for sustainable ARV financing in Vietnam.
Over the next semi-annual reporting period, USAID/SMART TA will work with VAAC to finalize the national proposal for ARV financing. We also work closely with the USAID-supported financing initiative led by Abt Associates, and provide additional communications technical assistance as needed.

project management

Following modifications in Years 1 and 3 across both our project management and implementation structures, all teams are functioning effectively. We are currently recruiting a strong, qualified leader to lead the HIV prevention team, and expect to recruit a national associate director of the care and treatment unit later in 2014.

annex 1

SMART TA workplan summary chart

The chart below represents a summary of USAID/SMART TA's sub-objectives, priority activities and key results for the FY14/COP13 period. Also included in the matrix is the geographic focus of each strategy; lead SMART TA Unit; and timeframe for completion of priority activities.

All interventions will continue to be developed, implemented, monitored and evaluated in full collaboration with the MoH (including VAAC, PHS, PAC, National TB Program and other departments or units), MoLISA, other key GVN ministries, SOs, PEPFAR and international implementing or funding partners.

Priority/Objective	Task Area	Result/Deliverable	Geographic Focus	Priority Activities	Lead SMART TA Team	Time Frame
Priority I| Improve cascade performance **[Strategic objective: Improve CoPC service delivery systems]**						
1.1 Respond to local epidemics in under-served areas	1.1.1 Expand MMT, "3 in 1," satellite and mobile services in highest priority districts	(R) Substantially more PLHIV and MMT clients access services in areas where they live or reside (D) Improved cascade performance as per agreed upon provincial targets	Targeted mountainous provinces/districts	(a) Establish 8 new main MMT clinics and 12 new satellite MMT dispensing sites (Haiphong, HCMC, Dien Bien,Quang Ninh, Nghe An, Thanh Hoa, and lao Cai. (b) Incorporate recommendations	MMT, C&T	(a) Q1-4 (b) Q1-4 (c) Q1-4 (d) Q2-4 (e) Q2-4

				and guidelines for 3-in-1 clinic startup procedures into SMART TA's TA services. (c) Develop protocols, SOPs and job aids to support 3-in-1 services and clinic management including integrating them into satellite and mobile service as feasible. (d) Confirm effectiveness and efficiencies gains of 3-in-1 clinics by comparing performance and productivity to single service sites. (e) Identify potential revisions in SOPs to streamline and reduce costs and delays in services.		
	1.1.2 Introduce reach, test, treat and retain mountainous model	(R) Test and treat model is endorsed by VAAC/GVN and implemented across NW region (D) 'Test and treat' strategy developed, implemented and monitored in selected provinces	Targeted mountainous provinces/districts	(a) Finalize concept paper with PEPFAR and VAAC. (b) Identify targeted areas and introduce concept to PACs and stakeholders. (c) Develop tools, training materials and plans (d) Monitor and revise strategy as per needs.	Tech Units, TACHSS	(a) Q1-2 (b) Q1-2 (c) Q2-3 (d) Q2-4
1.2 Increase the number / proportion of clients newly testing positive	1.2.1 Explore gender and LGBT access issues	(R) Issues of gender are considered in the design of policies and programs and stigma/discrimination are reduced, and access to services for LGBT and other vulnerable populations is	12 Provinces receiving SMART TA support, partner organizations and national	(a) Develop a protocol to assess issues relevant to LGBT people, women, and other vulnerable populations accessing services, service barriers and other gender-related issues in	Prev	(a) Q1-2 (b) Q2-3 (c) Q4

and immediately entering care and treatment		substantially increased (D) Gender/LGBT assessment with priority actions	agencies	SMART TA supported sites. (b) Implement the protocol and use findings to train and sensitize SMART TA staff and service provider staff on gender issues, stigma and discrimination and related issues, particularly those that are barriers to or affect the quality of services. (c) Findings are incorporated into TA services and used to revise policies and design new or restructure existing services and practices.		
	1.2.2 Understand reasons for late entry to HTC and HIV care and treatment	(R) Service models directly respond to challenges or barriers that clients face (D) Completed assessment(s), dissemination and use of findings	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Disseminate findings from the assessment of reasons for late entry to HTC and care and treatment services, and revise SC and program policies and marketing messages and efforts and service site policies as indicated. (b) Design innovative strategies for service promotion and demand generation including addressing common reasons for not seeking testing, treatment or dropping out of services such as "feeling healthy."	C&T, SI	(a) Q1 (b) Q1-2
	1.2.3 Introduce, strengthen and/or expand	(R) The number of clients newly testing HIV positive and entering the CoPC is	12 Provinces receiving SMART TA	(a) Expand Fansipan approach in 2 provinces.	Prev, SC, TACHSS	(c) Q1-2 (d) Q1

	service models to increase HTC uptake and C&T enrollment	substantially increased (D) *60*% KAPs screened as "high risk"; up to 40% increase in proportion of KAPs and partners testing for HIV; at least 50% of newly diagnosed PLHIV are first time testers; at least 70% newly diagnosed PLHIV are enrolled in care and treatment within 1 month of diagnosis; demand creation SC package; community supporter roles/responsibilities, job aides, SOPs	support, partner organizations and national agencies	(b) Introduce social media and engagement strategies focused on combination prevention packages including individual and group led interventions for MSM, TG, women and other KAP in HCMC/Hanoi. (c) Design and provide TA for counseling and effective referral of sex and needle sharing partners to combination prevention services including care and treatment if already infected. (d) Introduce MSM group-level outreach approach, in partnership with iSEE and HCMC/Hanoi private establishment owners serving MSM based on SafeTalk methodologies. (e) Establish partnership with USAID Healthy Markets Project to promote private sector/socially marketed commodities for MSM. (f) Restructure IDU outreach model to focus on KAP including incentives for deliverables.		(e) Q1-2 (f) Q1-2 (g) Q1 (h) Q1
	1.2.4 Support CoPC service provision in closed settings	(R) A HIV service system for closed settings is established and an increasing number of PLHIV in prison, jail or other	Closed settings in Vietnam approved for	(a) Work with VAAC and MOPS to finalize the strategic framework to provide TA to 18 GFATM supported service sites within	C&T	(a) Q1 (b) Q2-3 (c) Q2-3

		closed settings receive HTC and ART services (D) Closed settings strategic framework and TA plan; prisoners tested for HIV and ART-eligible PLHIV receive anti-retroviral therapy in targeted closed settings	TA	prisons. (b) Expand SMART TA support to 5 new prisons for HTC and care and treatment services including ART. (c) Develop a plan for evaluation of the TA with acceptable indicators. (d) The TA is implemented and evaluated.		(d) Q2-4
	1.2.5 Conduct advocacy and TA measures that have a major health impact	(R) Technical support leads to substantive changes in policies and practices for vulnerable populations and leads to substantial health impact (D) MMT campaign and feedback; FSW community-based harm reduction model strategy and roll out plan serving up to 1000 women	National	(a) Develop and implement MMT service sensitization campaign (b) Support piloting comprehensive community-based harm reduction model for FSWs in 1 province.	SC, Prev, MMT	(a) Q1-2 (b) Q1-4
1.3 Increase number / proportion of PLHIV initiating and adhering to ART and being retained within CoPC service system	1.3.1 Systematize community-based supporter systems across all USAID-supported provinces	(R) Community supporters become essential members of service delivery teams at the provincial level and assist in referring KAP for HTC and retaining PLHIV in the CoPC. Retention in the CoPC is increased and lost to follow-up of ART clients is significantly decreased. (D) Phased community supporter systems strengthening strategy for 12 provinces; up to 40% increase in proportion of KAPs	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Introduce concept to provincial health authorities and pilot in enhanced service sites in 2 provinces (b) Based on pilot experience and findings promote adoption and provide TA for the remaining provinces including: (i) finalizing M&E and communications plan and related tools; field test in targeted provinces; (ii)	Prev, C&T, SC	(a) Q1-2 (b) Q1-4

		and partners testing for HIV; at least 50% of newly diagnosed PLHIV are first time testers; at least 70% newly diagnosed PLHIV are enrolled in care and treatment within 1 month of diagnosis; 80% of PLHIV are retained in care (do not miss appointments); CD4 levels upon HIV initiation increase by agreed % in targeted sites			conducting provincial training for community-based, supporters across the 12 provinces using a phased training program.; (iii) setting up commodity/service social and commercial marketing system in collaboration with USAID Healthy Markets Project		
	1.3.2 Enhance pre-ART, early warning and LTFU responses	(R) The number of clients newly initiating ART significantly increases during year 3. An increasing percent of PLHIV on ART are adherent and retained in the service system (D) Pre-ART service package and approach; early warning system operationalized as part of SMART monitoring approach; LTFU interventions review and strategy	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Routinely monitor trends in each supported site using the cascade framework and other tools. (b) Identify reasons for late entry, repeat positives, weak referral linkages, and high dropout rates during pre-ART and other relevant issues. (c) Enhance the pre-ART package of services to promote retention until ART eligibility. (d) Utilize early warning indicators for those at high risk being LTFU. (e) Recommend policy and procedural changes to reduce costs and delay in initiating ART (per Vietnam guidelines). (f) Reduce loss to follow-up and re-engage clients in care through adapting and implementing innovative	C&T	(a) Q1-4 (b) Q1-4 (c) Q1-3 (d) Q2 (e) Q1-4 (f) Q1-4

			practices.		
1.3.3 Field test referral system models	(R) The effectiveness of referral systems is substantially increased and an increased number of clients are able to receive the services they need. (D) Operationalized referral systems in targeted provinces	Sites in the 12 provinces receiving SMART TA support, Pilot systems in enhanced sites	(a) Establish and sustain effective linkages between CoPC service providers and services need by PLHIV particularly TB diagnostic, care and treatment and MMT services. (b) Identify which services are available from which sites are available within the catchment area. (c) For each potential referral site, identify terms of service, client eligibility, operating hours, quality of services available, fees, and willingness to accept referrals. (d) Establish agreements (formal or informal) for referral services and procedures for accessing them and communication systems with the sites to facilitate referrals and confirm clients came and received services. (e) Solicit feedback from referred clients to confirm services were received and learn about problems in gaining access. (f) Evaluate SMS and other electronic systems for	SC (ICT), SI, C&T	(i) Q1-4 (j) Q1-2 (k) Q1-2 (l) Q1-2 (m) Q1-4 (n) Q4 (o) Q1-4 (p) Q1-4 (q) Q1-4

				reminding clients of referral needs, and appointments and facilitating communications with referral sites. (g) Support provinces in implementing effective SOPs for TB/HIV referrals. (h) Support integration of services as needed and feasible and effective in reducing costs, promoting retention and referral particularly for TB and drug use services. (i) Continue sub-agreement with the National TB Program to promote integration and referral services.		
	1.3.4 Conduct viral load assessments and provide TA on implementation of Testing Decision 1921	(R) Viral load testing is an integral part of the GVN CoPC system (D) Assessment findings and revised program strategies; defined TA role under Decision 1921	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Conduct viral load assessment among pre-ART clients in HCMC. (b) Develop concept paper for viral load assessment among ART clients sustained on ART (c) Provide TA for implementation of Viral Load Testing Decision 1921.	C&T, SI	(a) Q1-2 (b) Q1-2 (c) Q1-4
Priority II| Pay for Results **[Strategic objective: Improve CoPC service delivery systems]**						
2.1 Provide TA to ensure that resources are directly tied to	2.1.1 Field test individual performance-based incentive models in all	(R) Performance-based incentive systems help streamline costs and improve CoPC system performance (D) Operationalized individual	12 Provinces receiving SMART TA support	(a) Compile and share examples of individual performance-based systems (b) Develop and implement	Prev, SC, C&T	(a) Q1-3 (b) Q1-4

results; innovations and existing interventions are cost efficient; and expenditure/costing data aides GVN decision making and prioritization	USAID-supported provinces	performance-based systems in up to 12 provinces		coordinated individual performance-based systems in targeted areas.		
	2.1.2 Explore feasibility of site performance incentive models	(R) Site-based performance incentive models are trialed in Vietnam (D) Site performance incentive strategy and proof of concept plan	Targeted provinces/sites	(a) Develop site performance incentive strategy concept paper. (b) Pilot site performance incentive model in targeted enhanced sites, as per guidance from VAAC and PEPFAR.	C&T	(a) Q1-3 (b) Q3-4
	2.1.3 Establish private sector partnerships	(R) Private sector plays an increasingly important role in the GVN response (D) Private sector partnership agreements; amount/kind of support; collaborate agreement with Healthy Markets implementer	National	(a) Prepare private sector partnership advocacy materials. (b) Establish cooperative relationships with at least 2 private sector partners. (c) Collaborate with USAID Healthy Markets to expand private sector market share of critical commodities for KAPs	SC	(a) Q1-2 (b) Q1-4 (c) Q1-4
	2.1.4 Conduct and/or provide TA on analyses of service unit costs, expenditures and programmatic impact	(R) SMART TA economic assessments are invaluable to assessing and improving the efficiency of HIV/AIDS service delivery in Vietnam. (D) Expenditure data included in programmatic analysis reports; innovations strategies illustrate unit costs vis-à-vis conventional interventions; literature reviews; costing assessment(s)	National or provincial depending on the goal and type of analysis	(a) Identify questions and situations where economic analyses will substantially inform discussions and policy development. (b) Conduct reviews of relevant published literature, conduct costing studies or other types of assessments to generate economic information useful to SMART TA objectives and	SI, Finance	(a) Q1-3 (b) Q1-4 (c) Q1-4

				USAID and GVN goals and interests. (c) Continue support of human resources workload analyses in HCMC and other provinces.		
Priority III| Use Local TA **[Strategic objective: Strengthen GVN and SO technical capacity to deliver comprehensive HIV prevention, care and treatment services]**						
3.1 Design, implement and evaluate sustainable TA services / systems in Vietnam	3.1.1 Design and implement an effective "pull" TA system	(R) SMART TA pull TA systems are easily accessed by provincial and national level partners; are responsive to local/national needs; priorities and situations; and address common technical questions and challenges (D) Pull TA case management system; training and mentoring curricula; Pull TA reports and resources	All provinces, partner organizations and national agencies	(a) Design system to receive and assess, triage, and manage TA requests (b) Implement electronic tracking system to manage responses to requests and outcomes of TA (c) Identify common questions and issues and disseminate responses that are incorporated into training, blended learning, mentoring and other TA methods and activities	TACHSS	(a) Q1-2 (b) Q1-2 (c) Q1-4
	3.1.2 Design and implement at least 5 "push" TA initiatives	(R) Push TA initiatives address national/provincial priorities and respond to common challenges. They lead to substantive improvements in provincial service system capabilities and performance, and increase the quality of services (D) Push TA strategies and implementation plans	All provinces, partner organizations and national agencies	(a) Design push initiatives based on cascade assessment findings; relevant best practices from in or outside of Vietnam; availability of new technologies; feasibility and suitability of implementation in Vietnam; and potential outcomes and impact of implementing new capabilities. (b) Disseminate information; host	TACHSS	(a) Q1-4 (b) Q1-4

			technical consultations; pilot test and evaluate "push" programming; facilitate training and blended learning strategies		
	3.1.3 Develop and implement blended and technology-mediated learning strategy tracked through the SMART TA database	(R) Blended learning offerings respond to training needs across GVN and SO agencies (D) Blended learning strategy documentation; 2 online platforms; SMART TA capacity building database; online training tools (e.g. 10 modules for drug use and MMT services)	All provinces, partner organizations and national agencies	(a) Develop blended and technology-mediated strategy for in-service mentoring, accreditation and CME (b) Identify subject matter experts, and procure software and IT contracts (c) Establish 2 VAAC service demand creation and online learning platforms (d) Strengthen MMT online learning platform (e) Create videos, job aids and other relevant tools for blended learning and/or technology mediated TA	TACHSS SC, SI	(a) Q1-3 (b) Q1-3 (c) Q1 (d) Q1-2 (e) Q1-4
	3.1.4 Establish a sustainable network of well-trained, experienced provincial and national TA providers	(R) A well-trained, proficient and experienced network of TA providers in Vietnam provide TA on implementation issues within their own technical areas and geographic areas. They can be mobilized to assist other provinces when needed. They form a community of TA practice in Vietnam. The network is sustained beyond the duration of the SMART TA project.	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Identify TA network composed of 3 provincial representatives (each province) and 3 national representatives (each agency), as per standard criteria and assurances for TA sustainability (b) Facilitate basic training course (Module 1) on "How to become an effective TA Provider in Vietnam" (c) Provide ongoing mentoring	TACHSS	(a) Q1 (b) Q1 (c) Q1-4 (d) Q1-4

		(D) TA network selection criteria and process documents; TA training Modules 1-3; TA reports; GVN documentation on TA roles/responsibilities/ sustainability		and advanced training (Modules 2-3) to TA network (d) Support TA network members to provide TA services; utilize SMART TA pull TA system; participate in push TA Initiatives; and join TA teams working outside their province or on national issues		
	3.1.5 Develop portfolio of CoPC service delivery and intervention models	(R) SMART TA provides TA on a range of service and intervention models that have been adapted and proven effective in Vietnam (D) New service models identified, assessed for utility, and disseminated through provincial/national TA networks	12 provinces receiving SMART TA support, partner organizations and national agencies	(a) Identify multiple service models and interventions potentially relevant to urban and rural situations (b) Adapt and pilot models and interventions to ensure feasibility, suitability and effectiveness in Vietnam (c) Provide TA on implementation of models and interventions in Vietnam and monitor actual performance	TACHSS	(a) Q1-2 (b) Q1-4 (c) Q1-4
	3.1.6 Identify sustainable homes for TA systems	(R) TA institutions are identified and operational at provincial and national levels for training, supporting and accrediting CoPC TA providers (D) TA systems assessment, TA network membership roster, National Training Center operational plan and training materials, MoLISA training program strategy and tools, TA systems review	12 provinces receiving SMART TA support, partner organizations and national agencies	(a) Assess current roles of national / provincial institutions In HIV CoPC services and their willingness, preparedness, capacities to lead all or major components of the TA system (b) Support TA systems development within designated national institutions and incorporate key representatives into national TA network (c) Establish National Training	TACHSS, MMT, Prev	(a) Q1-3 (b) Q1-4 (c) Q1-2 (d) Q1-2 (e) Q1-2 (f) Q4

				Centre for drug use and MMT services at NIMH/HMU/Bach Mai and provide 6 months intensive mentoring support (d) Provide ToT and mentoring support to HCMC Medicine and Pharmacy University for drug use and MMT service TA system strengthening (e) Support MoLISA TA network to conduct case worker training program on community-based FSW harm reduction (f) Evaluate progress within national institutions in implementing TA systems, gaining needed capabilities and supporting TA services		
3.2 Develop, support and evaluate local technical assistance efforts	3.2.1 Support capacity building and strategy development efforts for a coordinated and sustainable HIV response	(R) Coordinated HIV response supported by well trained and capable GVN and SO implementers (D) # health workers successfully complete an in-service training program; # community health and paraprofessional social workers successfully complete an in-service training program; Number/kinds technical inputs for policy documents, SoPs, master plans, etc	All provinces, partner organizations and national agencies	(a) Develop and support classroom, practicum, and online training and mentoring of community-based supporters, doctors, counselors and other professional staff (b) Provide TA for the development of CoPC guidelines, SoPs, policy documents, etc. (c) Provide TA for revising regulatory guidelines for MMT dispensing sites (d) Provide TA for APCB accreditation and	TACHSS, MMT	(a) Q1-4 (b) Q1-4 (c) Q1-3 (d) Q1-4

				integrated MMT-HTC-ART master plan		
33. Expand and 3 3.3 Expand and enhance capabilities to provide SI, M&E, and research to improve services and systems	3.3.1 Apply SMART monitoring approach	(R) SMART TA monitoring systems appropriately classify sites and provide TA that improves sites with poor performance, sustains those that are effective, transitions sustainable sites for local ownership and management, and uses enhanced sites to pilot innovations and new technologies for Vietnam (D) SMART monitoring strategy implementation and mentoring plan; site classification upon baseline and at end of fiscal year; SMART monitoring reports and QI plans; level of effort of SMART TA staff commensurate with site classification needs	12 Provinces receiving SMART TA support, partner organizations and national agencies	(a) Classify current sites using standard criteria into one of four categories: 1) Improving, 2) Effective, 3) Sustainable, or 4) Enhanced. (b) Introduce a standardized monitoring system tailored to site classifications and actual needs with regular monitoring visits, contacts and performance reviews. (c) Transition those sites classified as sustainable to local management as feasible and PACs are willing. (d) Support enhanced sites to pilot innovative practices, interventions and service models. (a) Expand HIVQUAL system to all SMART TA supported sites and conduct QI exercises, document results in "improving" site performance or intervention success, and routinely monitor HIVQUAL system data.	TACHSS, SI, all tech units	(a) Q1 (b) Q1 (c) Q1-4 (d) Q1-4 (r) Q1-4
	3.3.2 Strengthen "one" national M&E system	(R) GVN uses one M&E system, irrespective of funder support (D) Provincial cascades; GVN-	12 provinces receiving SMART TA support,	(b) Provide TA to improve provincial M&E capacities, and streamline tools and	SI	(s) Q1-4 (t) Q1-2 (u) Q1-4

		supported M&E positions/departments; DQA/SMART monitoring plans and reports; M&E tools; quarterly feedback documents; QI strategies	partner organizations and national agencies	systems (c) Support provincial partners to identify and support M&E position/department (d) Provide data quarterly feedback to implementing partners and provide TA to facilitate data use and QI across targeted provinces		
	3.3.3 Design and/or provide TA for research that leads to substantial improvements in service and intervention implementation	(R) SMART TA provides TA on research that improves program and service system outcomes (D) Number/kind/findings of research studies, protocols, assessments	All provinces, partner organizations and national agencies	(a) Upon request by USAID, support surveys and studies led by partner and national organizations (b) Provide TA on survey or research design, protocol development, data collection and analysis, and potential application of findings (c) Facilitate and assist in ensuring ethic review and IRB approval of proposed surveys and studies (d) Lead or participate in the authorship of scientific publications on program experience, surveys or studies	SI	(v) Q1-4 (w)Q1-4 (x) Q1-4 (y) Q1-4
Priority IV| Reduce Donor Dependence **[Strategic objective: Support national and provincial policies, planning and implementation for sustainability]**						
4.1 Support	4.1.1 Develop collaborative	(R) SMART TA financial assistance is channeled	12 provinces receiving	(a) Convene initial meetings	TACHSS	(a) Q1

national and provincial policies, planning and implementation for sustainability	approach for the development, implementation and oversight of provincial sub-agreements	through sub agreements that reflect provincial priorities, address gaps and barriers in the service system and promote local ownership and management (D) Sub-agreements finalized and operational by 1 January 2014. Sub-agreements illustrate GVN cost share, reflect HRH plans, respond to cascade leaks, and reduce administrative burden	USAID/SMART TA support	with provincial representatives to discuss local needs, assess findings from cascade analyses and rapid assessments, and review local priorities. (b) Develop plans for use of available SMART TA resources. (c) Implement a monitoring and oversight process that reduces burden on provinces and SMART TA staff and increases flexibility of provinces to address local priorities. (d) Develop a sustainable strategy for HRH for each province receiving financial support from SMART TA.		(b) Q1 (c) Q1 (d) Q1
	4.1.2 Conduct rapid assessments in 3 new provinces	(R) Rapid assessments will reveal priority gaps and leaks in the service systems that need to be addressed and provide evidence for planning and targeting resources (D) Rapid assessment plans and reports	3 provinces	(a) Complete assessments in the 3 new provinces using a standardized protocol. (b) Develop short-term financial assistance and TA plans that address gaps, issues and needs that are incorporated as scopes of work for sub agreements. (c) Complete follow-up on the implementation on assistance plans in the 6 provinces with completed	TACHSS	z) Q1 aa) Q1-2 bb) Q1-2 cc) Q1-4 dd) Q1-2

				initial assessments (d) Convene semi-annual provincial cascade performance reviews and consultations in the 12 provinces (SI). (e) Develop individualized approaches to strengthen services in HCMC/Hanoi using the cascade analyses and other tools.		
	4.1.3 Track and monitor GVN financial contributions at all levels in provinces receiving USAID/SMART TA support	(R) SMART TA is able to estimate the amount of and trends in local investment in provincial HIV/AIDS programs (D) Proportion of GVN cost share/year	12 provinces receiving USAID/SMART TA support	(a) Document and track the amount/type of cost share in sub-agreements	TACHSS, Finance	(a) Q1
	4.1.4 Provide TA on the extension of health insurance coverage in targeted CoPC sites	(R) A clear plan is developed to increase access for PLHIV to health insurance that maximizes allowable benefits to support their HIV/AIDS care and treatment (D) Health insurance programming expansion plan; health insurance provided to PLHIV in additional targeted sites	12 provinces receiving USAID/SMART TA support	(a) Continue to pilot a health insurance model in HCMC. (b) Synthesize lessons learned from experience with health insurance systems in An Giang, HCMC and other provinces. (c) Provide TA to scale up a health insurance model to other provinces.	TACHSS	(a) Q1-4 (b) Q2 (c) Q2-4
	4.1.5 Provide scientific evidence on	(R) Policy discussions and decisions increasingly reflect the most up-to-date scientific	VAAC, MOLISA, MOH, PACs	(a) Identify critical information needs relevant to the goals of policy-making	SI, all technical units	(a) Q1-4 (b) Q1-4

	global best practice and lessons learned to inform national and provincial policy discussions and decisions	evidence, research findings, global best practices and Vietnam program experience (D) Number/kind of literature reviews and policy papers	and other national and provincial Institutions and partners	discussions and decisions. (b) Conduct literature reviews and surveys of practices around the world regarding high priority topics for Vietnam to identify case studies and relevant program experience and practices potentially feasible for Vietnam. (c) Summarize and present to national and provincial partners to support their discussions and decisions.		(c) Q1-4
	4.1.6 Assist VAAC and other national institutions to advocate for increased ARV and methadone financing	(R) VAAC is able to make a compelling successful proposal for increased financial for funding and sustain HIV/AIDS programs and services in Vietnam donors reduce their financial support (D) National ARV financing proposal, number/kind/outcomes of ARV financing efforts	National	(a) Support VAAC to develop and finalize the national proposal to ensure financing of ARV drugs. (b) Research technical issues as needs arise to support planning and deliberations. (c) In collaboration with VAAC, organize and support meetings, workshops, and forums on ARV financing, procurement and distribution. (d) Develop a communications campaign for sustainable financing for policy makers and the public.	TACHSS	(d) Q1-2 (e) Q1-4 (f) Q1-4 (g) Q2-4

annex 2 results against targets

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY2014		Achieved Year 3 FY2014		Rationale/ Description
					DSD	TA	DSD	TA	
Objective 1: Deliver quality services within the CoPC									
1. Number of key populations reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required (disaggregation by key population types: FSW, male PWID, female PWID, MSM/TG and MSM/TG who are PWID (subset of MSM/TG)	Output	Quarterly	Program	59,717	45,100		21,302		47.2% achieved (DSD) 11,465 males, including 5093 MSM and 6169 PWID; and 9837 women, including 9030 FSWs) Year 3 reductions reflect the transition or consolidation of prevention interventions and greater targeting of high risk/needs individuals
2. Number of people who inject drugs (PWID) on medication assisted therapy.	Output	Quarterly	Program	3,606	4,580	11,319	5,295 total clients, with 4,806 clients on MMT for 6 months or more	2,439	108.2% achieved (DSD) 28 GFATM, HAARP and VAAC-US CDC facilities have received TA from USAID/SMART TA over the reporting

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY2014		Achieved Year 3 FY2014		Rationale/ Description
					DSD	TA	DSD	TA	
									period
3. % HIV positivity rate among KPs	Outcome	Quarterly	Program	N/A	7%		5.7%		
4. Number of individuals who received HIV Testing and Counselling (HTC) services for HIV and received their test results (disaggregation by type of services CITC or PITC, by DSD, TA or Neither, by counselling type, by result, by population, by sex)	Output	Quarterly	Program	50,380	60,450	25,000	23,581		39% achieved (DSD) Numbers reflect HIV tests, rather than individuals.
5. Proportion of KP individuals reached in province during reporting period	Outcome	Annually	Province	N/A	60% (targeted provinces)	N/A			To be reported on an annual basis
6. Proportion of KP individuals who received testing results and post-test counselling in province during reporting period	Outcome	Annually	Province	N/A	5 – 40% increase (targeted provinces)	N/A			To be reported on an annual basis
7. Percentage of FSW reporting the use of a condom with their most recent partner/client	Impact	2-3 years	IBBS	N/A	77%		SSW: 86-98% (median 96%) VSW: 88-99% (median 96.5%)		

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY2014		Achieved Year 3 FY2014		Rationale/ Description
					DSD	TA	DSD	TA	
8. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Impact	2-3 years	IBBS	N/A	95.9%		89-98%, Median 93.5%		
9. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results, by key population group	Impact	2-3 years	IBBS	N/A	PWID: 20% FSW: 50% MSM: 20%		SSW: 33-81%, Median 54% VSW: 58-98%, Median 74% PWID: 30-68%, Median 52.5% MSM: 56-76%, Median 74%		

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY 2014		Achieved Year 3 FY 2014		Rationale/Description
					DSD	TA	DSD	TA	
10. Number of HIV positive adults and children receiving a minimum of one clinical service at facility (disaggregation by DSD, TA and Neither) (SMART TA-supported sites)	Output	Quarterly	Program	16,778	21, 110	650	19,688		
11. Number of adults and children with advanced HIV infection that are newly enrolled on ART (SMART TA-supported sites)	Output	Quarterly	Program	3000	2500	450	1334		53.4% achieved (DSD); closed setting service provision begins during next SAR period
12. Number of adults and children with advanced HIV infection receiving ART (CURRENT) (SMART TA-supported sites) (disaggregation by DSD, TA or Neither).	Output	Quarterly	Program	12,479	15,345 (+10%)		16,983		110.7% achieved (DSD)
13. Proportion of ARV patients who initiate ART within 30 days after qualification in last 6 months (SMART TA-supported sites)	Outcome	Annually	HIVQUAL	-	≥75%		69.7%		Round 4 HIVQUAL data
14. Percentage of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy (SMART TA-supported	Outcome	Annually	Program	88%	≥90%		84.2%		93.5% achieved (DSD); provinces with low survival are Nghe An (67%), Dien Bien (77%) and An

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY 2014		Achieved Year 3 FY 2014		Rationale/Description
					DSD	TA	DSD	TA	
sites)									Giang (76%)
15. Percentage of HIV positive patients who were screened for TB in HIV care or treatment settings	Outcome	Annually	Program		90%		75.6%		
16. Median CD4 level when initiating ARV treatment among PLHIV in the last 6 months (SMART TA-supported sites)	Outcome	Annually	HIVQUAL	41% (CD4 ≤ 100)	28% (CD4 <= 100)		33.7% (CD4 <= 100)		Round 4 HIVQUAL data
17. Total number of PLHIV in province reported from HIV INFO by the end of reporting year	Outcome	Annually	Province (HIV INFO)	N/A	5 – 10% increase (targeted provinces)				To be reported on an annual basis
18. Number of people currently living with HIV at communes/wards reported from D28 by the end of reporting period	Outcome	Annually	Province (D28)	N/A	5 – 10% increase (targeted provinces)				To be reported on an annual basis
19. Number of new patients registered at OPCs in the province during reporting period	Outcome	Annually	Province	N/A	5 – 10% increase (targeted provinces)				To be reported on an annual basis
20. Number of patients currently registered at OPCs in the province during reporting period	Outcome	Annually	Province	N/A	5 – 10% increase (targeted provinces)				To be reported on an annual basis

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY 2014		Achieved Year 3 FY 2014		Rationale/Description
					DSD	TA	DSD	TA	
21. Number of patients newly started ARV treatment at provincial facilities in the reporting period	Outcome	Annually	Province	N/A	5 – 10% increase (targeted provinces)				To be reported on an annual basis
22. Number of patients currently on ARV treatment in province by the end of reporting period	Outcome	Annually	Province	N/A	5 – 10% increase (targeted provinces)				To be reported on an annual basis

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY 2014		Achieved Year 3 FY 2014		Rationale/ Description
					DSD	TA	DSD	TA	
Objective 2: Strengthen GVN and CSO technical capacity									
23. Number/type of priority "push" TA initiatives	Output	Quarterly	Program	1 (transition)	5		5		See narrative for detailed description of push TA initiatives
24. Number/type of health care workers (disaggregated by gender) who successfully completed an in-service training program in the last 12 months	Output	Quarterly	Program	1,167	1,485 (+10%)		739		This indicator will be removed from the MER requirements in late FY14
25. Number/kinds of community health and paraprofessional social workers (disaggregated by gender) who successfully completed an in-service training program	Output	Quarterly	Program	1,167	1,445 (+10%)		598		This indicator will be removed from the MER requirements in late FY14
26. Number/type of TA deliverables (e.g. policies,	Output	Quarterly	Program	As	As				See narrative for detailed

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY 2014		Achieved Year 3 FY 2014		Rationale/ Description
					DSD	TA	DSD	TA	
SOPs, curricula, standards) developed with assistance from USAID/SMART TA				reported	reported				description of push TA initiatives
27. Number/type of GVN institutions receiving TA from USAID/SMART TA	Output	Quarterly	Program	15	25		20		
28. Number/type/results of TA needs assessments and recipient evaluation surveys completed	Output	Quarterly	Program	N/A	As reported		2		2 RAR conducted (Quang Ninh, An Giang)
29. Number/proportion of provinces receiving push TA that adopt the interventions, program approaches or integrate new technology	Outcome	Annually	Program	-	12		9		All SMART TA-supported provinces are using the cascade framework and are trialing the enhanced outreach approach
30. Number/proportion of provinces and/or programs requesting TA from USAID/SMART TA	Outcome	Annually	Program	N/A	15		14		
31. Number/proportion of SMART TA-supported provinces and/or programs with annual TA plans	Outcome	Annually	Program	N/A	12		9		All SMART TA-supported provinces have developed an annual TA plan as per the sub-

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY 2014		Achieved Year 3 FY 2014		Rationale/ Description
					DSD	TA	DSD	TA	
									agreement process
32. Number/type of GVN and SO staff (national, provincial, district, facility) in operational TA networks	Outcome	Annually	Program	N/A	50		120		120 individuals have been nominated to participate in provincial CoPC TA networks (excludes MMT mentorship system)
33. Number/proportion of institutions providing TA to GVN or CSOs at the national, provincial or district levels after receiving USAID/SMART TA technical assistance	Outcome	Annually	Program	3	12 (9 provinces, 3 CSOs)		12		All PACs and 3 CSOs have been trained as master trainers in the enhanced outreach approach
34. Number/proportion of facilities with assessed improvements as per SMART technical monitoring classification criteria and technical program standards	Outcome	Annually	Program	N/A	40 (C&T)		24		Baseline assessment carried out across 24 care and treatment facilities

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY 2014		Achieved Year 3 FY 2014		Rationale/ Description
					DSD	TA	DSD	TA	
35. Number/type of cascade analyses (including gender cascades) undertaken with technical assistance from USAID/SMART TA	Output	Quarterly	Program	N/A	12				To be reported on an annual basis
36. Number/type of research studies completed and/or analyzed and applied in Vietnam	Output	Quarterly	Program	4	5				To be reported on an annual basis
37. Number/type of surveillance activities carried out with technical assistance from USAID/SMART TA	Output	Quarterly	Program	3	2				To be reported on an annual basis
38. Number of individuals trained on operational research proposal development, the collection, use, and analysis of data and strategic information for the management and implementation of the HIV program	Output	Quarterly	Program	55	TBD				To be reported on an annual basis
39. Number/proportion of provinces undertaking cascade analyses of the HIV response and implementing targeted service improvement	Outcome	Annually	Program	N/A	12				To be reported on an annual basis

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY 2014		Achieved Year 3 FY 2014		Rationale/ Description
					DSD	TA	DSD	TA	
action plans based on these analyses									
40. Number/proportion of provinces routinely using cascade metrics in reporting exercises	Outcome	Annually	Program	N/A	9				To be reported on an annual basis

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY 2014		Achieved Year 3 FY 2014		Rationale/ Description
					DSD	TA	DSD	TA	
Objective 3: Transition ownership of CoPC services									
41. Number/type/outcome of cost unit and/or expenditure analyses in the last 12 months	Output	Quarterly	Program	1 (PEPFAR expenditure)	5		3		Care and treatment, MMT and HTC expenditure analyses
42. Number/type/outcome of performance incentive initiative in the last 12 months	Output	Quarterly	Program	N/A	3 (Fansipan, HHW, enhanced outreach)		4		4 PBI schemes are in the process of field testing
43. Number/proportion of SMART TA-supported provinces undergoing joint provincial planning exercises	Output	Quarterly	Program	N/A	8 (NW provinces, HCMC, Can Tho, Haiphong)		9		All SMART TA-supported provinces underwent a collaborative planning process during the subagreement development process
44. Number of currently funded, dedicated positions for managing an effective HIV response transitioned from PEPFAR funding to GVN.	Outcome	Annually	Province/ program	N/A	70		117		This number represents key MMT positions transitioned to GVN funding

Key Performance Indicators	Level	Periodicity	Data Source	Baseline	Intermediate				
				Year 1	Target Year 3 FY 2014		Achieved Year 3 FY 2014		Rationale/ Description
45. Proportion of funding for CoPC services provided by GVN in SMART TA-supported sites or interventions (proportion of GVN cost share per year).	Outcome	Annually	Province/ program	20% efficiency gains	10%		8.6% (total expenses)		
46. Number/type of sites, management and/or interventions transitioned to GVN or CSOs	Outcome	Annually	Province/ program	5 sites/ interventions	2 sites/ interventions (e.g. Blue Sky, An Duong)		7 MMT clinics		
47. Unit cost per ART patient per year	Outcome	Annually	Province/ program	As reported	As reported		$45 USD (excluding drugs)		
48. Number/proportion of provinces that have integrated joint planning approaches into existing provincial planning, implementation and budgeting cycles	Outcome	Annually	Province/ program	N/A	1		1 (HCMC)		

annex 3 MMT scale up

Province	Clinic	Main clinic		Disp satellite	SMART TA Support Opening Progress					Notes
		MMT with OPC/HTC	Main clinic		Needs assessment	Renovation, equipment procured	Staff training	Clinic accreditation	Patient induction	
Hai Phong	Vinh Niem	1	1		Yes	Yes	Yes	Yes	1-Apr-14	
	Phu Ninh - Thuy Nguyen			1	Yes	On-going	May-14			
	Thuy Trieu - Thuy Nguyen			1	Yes	On-going	May-14			
	Kenh Duong - Le Chan			1	Yes	On-going	May-14			
	Do Son (Duong Kinh)	1		1	Yes	Wait for local funding	1-May			
Nghe An	Que Phong	1	1		Yes	Yes	Yes	Yes	May-14	Needs salary support from Nghe An local government
	Quy Chau	1	1		Yes	Yes	Yes			Requires leadership from Quy Chau Hospl, and salary support from Nghe An local gov.
	Dien Chau	1	1		Yes					Implementation not feasible, leadership and staff constraints.
	Tuong Duong	1	1		Yes	Planning	May-14			
Thanh Hoa	Hoang Hoa		1		Yes	Yes	May-14	On-going	May-14	
Quang Binh	Dong Hoi city		1		Yes	Planning	May-14			Plan to open in June 2014
Can Tho	Thot Not	1	1		Yes	Yes	Yes	April 14-18, 2014	May-14	
HCMC	Dist 1 (Binh Thanh)			1	Yes					No space for MMT dispensing
	Dist 12 (Binh Thanh)			1	Yes	Yes	Yes	May-14		Plan to open in July 2014
	Dist 10 (Dist 8)			1	Yes	Awaiting local funding	May-14			Plan to open in Sept 2014
	Dist 7 (Dist 8)			1	Yes	Awaiting local funding	May-14			Plan to open in Sept 2014
	Tan Binh Dist		1		Yes	Yes	Yes	Yes	May-14	
Dong Nai	NIMH No2		1		No					NIMH proposal yet not approved by Dong Nai province. This is to be a national training center.
Dien Bien	Dien Bien Dong		1		Yes					MMT is needed, however, Dien Bien Don leadership and commitment is insufficient.
	Tua Chua	1	1		Yes	On-going	May-14			Plan to open in Sept 2014
	Thanh Chan (Dien Bien dist)			1	Yes	On-going	Yes			Waiting for Provincial master MMT plan and financial support from province. Plan to open in Sept 2014
	Na Tau (Dien Bien dist)			1	Yes	Awaiting local funding	May-14			
	Thanh Luong (Dien Bien dist)			1	Yes	Awaiting local funding	May-14			
	Hoi Long (Tuan Giao dist)			1	Yes	Awaiting local funding	May-14			
	Muong Pon (Dien Bien dist)				Yes					Needs leadership from Muong Pon leaders. Not a highly concentrated epidemic area
	Pom Lot (Dien Bien dist)			1	Yes					Need commune health station support staff
Lao Cai	Bao Thang	1	1		May-14					
	Van Ban	1	1		Yes		Yes			Need provincial support for staff.
	Bat Xat	1	1		Yes	On-going	Yes			
	Total	**11**	**15**	**13**						

annex 4 Gender report

(attached in separate document)

annex 5 SMART TA stories

I | Scaling methadone maintenance treatment in Vietnam

In Vietnam, sharing of injection drug use equipment is the primary mode of HIV transmission. Injection drug users (IDUs) account for around 45% of all HIV cases in the country. Multiple prevention interventions have been implemented since the 1990's in order to reduce and control the spread of HIV among IDUs, including information, education and communication activities and needle and syringe programs (NSPs). In 2008, the Vietnam Authority of HIV/AIDS Control (VAAC) opened the first methadone based opioid substitution treatment (OST) clinics in Vietnam. USAID/SMART TA has been a major contributor to the scale up of HIV prevention interventions to reduce the spread of HIV among IDUs in Vietnam.

Methadone Maintenance Treatment (MMT) treats opioid dependence, directly helps to reduce the practice of injection drug use, and is a highly effective intervention for reducing both HIV infection and transmission. The Government of Vietnam has set an ambitious goal of reaching 80,000 heroin users with MMT by the end of 2015. As of March 2014, around 16,000 patients were enrolled in 81 MMT clinics – leaving a gap of 64,000 patients still awaiting treatment. Demand for treatment services among drug users remains high, and the number of provinces requesting support for MMT programs continues to grow. To date, 41 provinces have requested a total of 161 new MMT clinics or satellite sites.

Multiple national and international agencies are collaborating to meet this demand and achieve national targets. Built on initial efforts and most recent increased support through USAID/SMART TA project, USAID and FHI 360 Vietnam have been important technical partners since 2008 collaborating with the Government of Vietnam and other development partners to scale the national MMT program.

Key activities undertaken include:

- *Establishment of MMT clinics*

Since 2008, with financial support from USAID and though technical assistance from USAID/SMART TA, the Government of Vietnam has supported MMT clinics, developed clinical guidelines, conducted staff training, held conferences to review the evidence on MMT, and evaluated local clinical and economic outcomes of treatment. We also support 20 clinics through USAID/SMART TA project, and provide training and mentoring to an additional 61 clinics through funding from CDC between 2009 and 2013. In 2014-15, it is in USAID/SMART TA plan that we will provide technical support to establish 18 new main clinics and 9 satellite sites.

- *Development of an integrated clinic model*

We have developed a 3-in-1 (HTC-MMT-ART) integrated clinic model for HIV testing and counseling (HTC), MMT, and antiretroviral treatment (ART) that is now being implemented in Ho Chi Minh City, Quang Ninh, Dien Bien, Can Tho, Lao Cai, Quang Tri, and Nghe An. In this model, health center clinical staff simultaneously treat both drug addiction and HIV infection. This reduces total costs, enhances coordinated care, and improves retention of patients.

- *Development of an MMT satellite model*

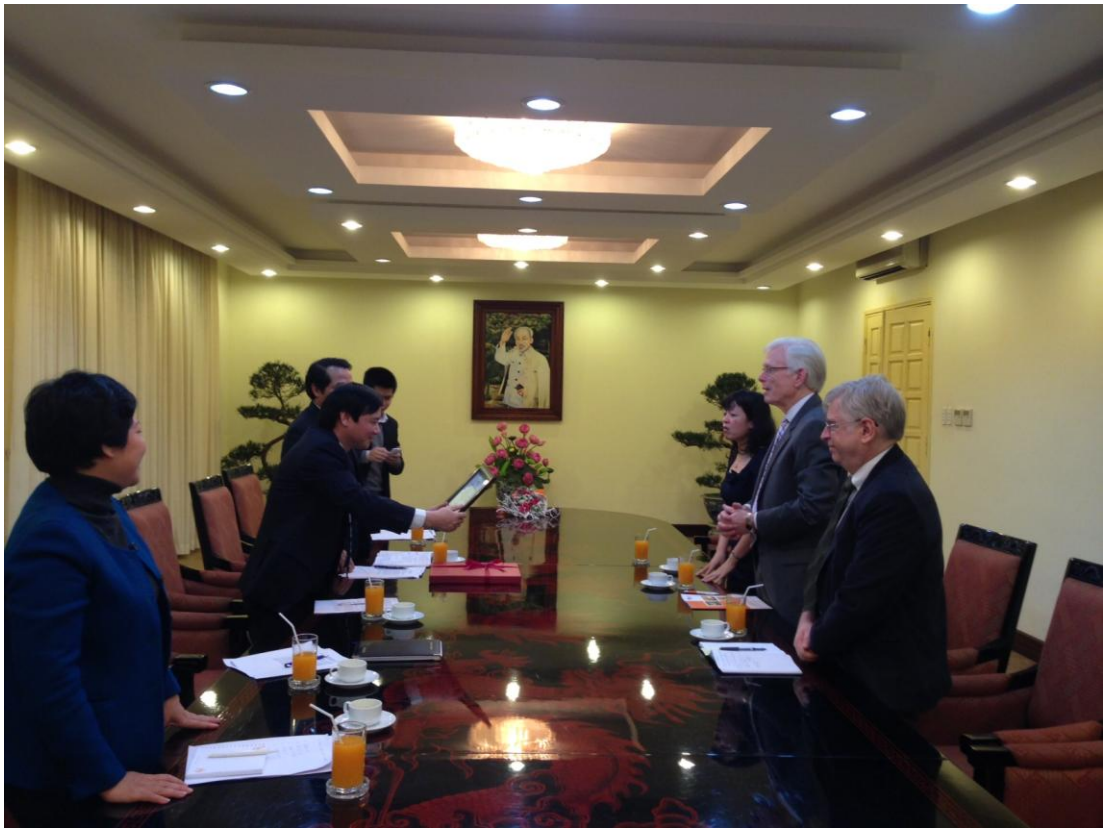
In 2013, the USAID/SMART TA project helped design and provided TA on a 'hub-and-spoke' MMT satellite clinic model to improve access to treatment in rural areas and to expand service capacity in cities. In this model, host MMT clinics manage up to three 'satellite' methadone-dispensing sites located in health stations or inter-district polyclinics. Only stable patients are eligible for transfer from the host site to a satellite. A doctor from the host clinic visits the satellite regularly to provide technical assistance (TA) and to ensure quality of services.

- *Support in establishing a co-payment financing model for MMT*

The USAID/SMART TA project has also assisted Hai Phong and Lao Cai to establish the first two co-pay MMT clinics in Vietnam. In the co-pay model, patients pay a minimal fee (currently 10,000 VND/day, or about $0.50 USD/day) to help cover costs. The Project conducted research to determine affordable family costs and advocated strongly for lowest feasible fees and no fees for disadvantaged patients. Implementation of the co-pay model is essential for success of the national scale up and sustainability of the MMT program. International donors have programmed gradual reductions in fiscal support over the next five years, and the Government's National Treatment Program (NTP) has planned reductions in its scope as well.

- *Generating evidence for decision- and policy-making*

The USAID/SMART TA project has been actively involved in education, evidence-based advocacy, and local studies of costs and outcomes to better inform program planning and policy-making. Technical staff have conducted many educational seminars on drug dependence, HIV control and treatment, and community-based voluntary treatment models. In Hai Phong, cost analyses were prepared comparing MMT to local compulsory '06 Centers. These analyses found dramatic reductions in local crime and reported illicit drug use, while employment rates and family satisfaction factors increased.



With increasing MMT expansion activities, it has also been essential to provide similar information for leaders of provincial government bodies. For example, USAID/SMART TA provided organization and technical support to the Government Advisory Board for a national workshop (held on January 6, 2014) to review the evidence for MMT as an effective intervention for reducing drug use, HIV risks, and crime. This conference produced a vigorous call from the central government to more rapidly scale up MMT efforts in all provinces.

- *Media campaigns on MMT*

A media campaign entitled, *Methadone is the Smart Solution: Health for Patients, Hope for Families, and Safety for Communities*, directed at policy makers, families of drug users, and the general public, was carried out by USAID/SMART TA project from November 2013 to January 2014. The aim was to raise understanding and awareness of MMT and to position it as an economic and effective intervention for heroin use. As part of the campaign, a photo exhibition was held, short video clips were aired on local television channels, MMT brochures distributed, and press releases were provided for media outlets.

The Project was successful in engaging media as demonstrated through the 22 print articles, 24 online articles and 5 case studies published during the campaign period. In addition, support and commitment to MMT from policy-makers was strengthened.

Following the campaign, two key meetings were held by the government in January 2014. The Advisory Board workshop on 6 January was followed by a

Coordination Meeting held by MoH/VAAC on 21 January to review the national MMT program and agree on future directions. High-ranking government officials showed their commitment and support to rapidly scaling MMT in Vietnam.

USAID/SMART TA's role in supporting the scale-up MMT services in Viet Nam was officially recognized during the 21 January Coordination Meeting, chaired by Dr. Pham Duc Manh, Deputy Director of VAAC, and attended by international donors. During this meeting, several key commitments were made including:

- *Acceleration of completion of guidelines for stable patients so they can be treated in satellite clinics* in the hub-and-spoke system of MMT clinics (as designed and proposed by USAID/SMART TA project). Such a satellite system will increase capacity, reduce per capita costs, and offer services closer to patient homes.

- *Endorsement of USAID/SMART TA as an official entity supporting national methadone program local mentors and trainers to address the capacity building/training needs of new MMT clinics*. Local mentors will be recruited from advanced MMT clinics, and USAID/SMART TA will collaborate with VAAC to train them.

These two commitments are a testament of the joint USAID and SMART TA efforts, accomplishment, and collaboration in scaling up MMT in Vietnam to achieve ambitious national goals.

II | Good prison health is good public health

In Vietnam, HIV prevalence in prisons is reported to be as high as 28%, with most inmates acquiring infection prior to incarceration[5]. To address this issue in a timely manner, FHI 360/SMART TA has been working with relevant stakeholders, including the Ministry of Public Security and Ministry of Health, to initiate HIV / interventions in closed settings. During January-March 2014, a series of site assessments were conducted in five provinces: Quảng Ninh, Hà Nam, Bắc Giang, Nhinh Thuận và Hậu Giang and their respective prisons Quảng Ninh, Nam Hà, Ngọc Lý, Sông Cái and Kênh 5. Site assessments focused on prisoner care, treatment needs, infrastructure, staffing, training needs, and informed interventions to increase availability, accessibility and utilization of quality HIV prevention, care and treatment services.

HIV initiatives in prisons were well received by local leaders. FHI360/ SMART TA worked with provincial authorities to identify priorities for 2014 - 2015 that strengthen provincial technical capacity for HIV care and treatment services in closed settings and retain HIV patients in care and treatment through effective system linkages between prisons and the community.

FHI 360/SMART TA has developed a series of documents to kick start service provision. Provincial technical assistance plans were drafted, taking into account provincial epidemics and prison characteristics. Referral systems have been strengthened, linking prisons with provincial health care systems for those prisoners who need further medical assistance. Post-release procedures have been articulated to ensure that HIV positive individuals will be retained in care and treatment services. And training materials have been developed to strengthen CoPC service provision capacity.

Starting in June 2014, HIV services will be provided in these prisons. This first-ever HIV initiative showcases evidence-based programming and demonstrates good coordination and collaboration efforts between prison and health management officials.

5 HIV and AIDS in places of detention, WHO 2008